MEDICAL CARE IN THE WORKHOUSES IN BIRMINGHAM AND WOLVERHAMPTON, 1834-1914

by

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ABSTRACT

This study of the medical role of the urban workhouses of Birmingham and Wolverhampton after the New Poor Law addresses the following questions: what were the standards of medical and nursing practice and what treatments were used to alleviate inmates' suffering? It considers the nature of illnesses encountered covering acute non-infective illnesses, infectious disease and chronic disability, and highlights the important role the workhouse played in providing institutional care, especially in the isolation of epidemic diseases. Birmingham workhouse had a well-developed medical service prior to the New Poor Law and this continued until the mid-nineteenth century. By comparison, Wolverhampton workhouse did not meet satisfactory levels of medical and nurse staffing until near the end of the century. The study provides a new perspective on medical care in workhouse infirmaries by showing how standards varied over time within the same institution and how medicalisation of the workhouse began in the early years after the New Poor Law. Medical care in workhouses has been viewed as important only in the context of the development of the National Health Service, but this study demonstrates that it provided significant, and at times high quality, medical treatment for the poor.

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ABBREVIATIONS

AMO	Assistant Medical Officer
BBG	Birmingham Board of Guardians
BCL	Birmingham Central Library
BPP	British Parliamentary Papers
BUB	Birmingham Union Board
CEB	Census Enumerators' Books
CL	Commissioner in Lunacy
CMB	Central Midwives Board
CsL	Commissioners in Lunacy
d	pence
DMO	District Medical Officer
FRCS	Fellow of the Royal College of Surgeons
GHAR	General Hospital Annual Report
GPC	General Purposes Committee
HC	House Committee
HS	House Surgeon
HSC	House Sub Committee
IHSC	Infirmary House Sub Committee
IMC	Infirmary Management Committee
IMO	Infirmary Medical Officer
ISC	Infirmary Sub Committee
LGB	Local Government Board
MD	Doctor of Medicine
MJ	Master's Journal

MO	Medical Officer
MOH	Medical Officer of Health
MOsH	Medical Officers of Health
MPA	Metropolitan Poor Act (1867)
NPL	New Poor Law
PLB	Poor Law Board
PLCs	Poor Law Commissioners
RI	Register of Insane
s	shillings
TB	Tuberculosis
TNA	The National Archives
VGPC	Visiting and General Purposes Committee
WALS	Wolverhampton Archives and Local Studies
WBG	Wolverhampton Board of Guardians
WC	*Wolverhampton Chronicle*
WIMC	Workhouse Infirmary Management Committee
WISC	Workhouse Inquiry Sub Committee
WJ	*Wolverhampton Journal*
WMC	Workhouse Management Committee
WMO	Workhouse Medical Officer
WVC	Wolverhampton Visiting Committee

CHAPTER 1

THE NEW POOR LAW

AND THE INDOOR MEDICAL SERVICE

Introduction

Although the literature on poor law history is extensive, sick paupers have largely been neglected within this body of knowledge, despite the inextricable link between illness, disability and poverty.[1] One possible reason for the paucity of research is the scarcity of sources relating to poor law medical relief and the fleeting references to medical care within poor law archives.[2] More important has been the lack of definition of ill health as a cause for poor law relief, lending some historians to suggest that distinguishing medical relief from other forms of help is not important

[1] The classic text on the history of the poor law arguably remains that written by the Webbs, *English Poor Law History,* published in London in 1927, although many studies since have taken a more critical, if less integrated, approach by investigating particular aspects of poor law administration. Major studies of the national system include: D. Fraser (ed.), *The New Poor Law in the Nineteenth Century*, London, 1976; K. Williams*, From Pauperism to Poverty,* London, 1981; M. E. Rose (ed.), *The poor and the city: the English poor law in its urban context, 1834-1914*, Leicester, 1985; A. Digby, *British Welfare Policy: Workhouse to Workfare*; D. Englander, *Poverty and Poor Law Reform in Nineteenth Century Britain*, London, 1998; L. H. Lees, *The Solidarity of Strangers*, Cambridge, 1998; A. Kidd, *State, Society and the Poor in Nineteenth-Century England*, Basingstoke, 1999. A regional or local analysis is contained in: M. Fissell, *Patients, Power and the Poor in Eighteenth-Century Bristol*, Cambridge, 1991*;* Brundage, *The English Poor Laws 1700-1930*; S. King, *Poverty and welfare in England 1700-1850*, Manchester, 2000. Those devoted primarily to the workhouse include: A. Digby, *Pauper Palaces*, London, 1978; M. A. Crowther, *The Workhouse System 1834-1929*, London, 1981; F. Driver, *Power and Pauperism*, Cambridge, 1993; M. Higgs, *Life in the Victorian and Edwardian Workhouse*, Stroud, 1997; S. Fowler, *Workhouse: The People, The Places, The Life Behind Doors*, Richmond, 2007.

[2] The main published studies covering the medical field are: R. G. Hodgkinson, *The Origins of the National Health Service: the Medical Services of the New Poor Law 1834-71*, London, 1987; M. Flinn, 'Medical Services under the New Poor Law' in D. Fraser (ed.) *The New Poor Law in the Nineteenth Century*, London 1976; J. V. Pickstone, *Medicine and Industrial Society*, Manchester, 1985; H. Marland, *Medicine and Society in Wakefield and Huddersfield 1780-1870*, Manchester, 1987; J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse*, Rochester, 2013; A. Gestrich, E. Hurren and S. King (eds), *Poverty and Sickness in Modern Europe*, London, 2012.

and that the sick poor are not worthy of study as a specific subgroup.[3] Mary Fissell found, in her study of the poor in eighteenth-century Bristol, that medical care for many paupers was such an integral part of their welfare support that it was not possible to make a clear distinction between health care and poor relief. The support provided to families often defied separation into medical and welfare components. However, she did accept that illness could be a clearly defined point of entry to relief for some paupers.[4] Indeed, even when sickness or physical disability was not a key reason for an application for relief, it was often a necessary accompaniment for success. Furthermore, relief granted on the basis of unemployment often unmasked underlying sickness.[5] Alannah Tomkins' view is that there is much to be learned from trying to distinguish 'the sick from the total pool of "the poor"' and from examining the provision of identifiable medical relief.[6] As a result of the limited dedicated research on sick paupers, there remain gaps in the knowledge of the nature and role of poor law medical care and an inadequate understanding of its importance in the life cycle of illness among paupers.[7]

Additionally, the poor law institutional medical service has been less intensively researched by historians than outdoor medical relief. This is difficult to comprehend since sickness was very often the major reason for admission to a workhouse and an increasing proportion of sick paupers were admitted as the nineteenth century

[3] S. King, 'Poverty, Medicine and the Workhouse in the Eighteenth and Nineteenth Centuries', in Reinarz and Schwarz (eds), *Medicine and the Workhouse*, p.245; A. Tomkins, '"Labouring on a bed of sickness": The material and rhetorical deployment of ill-health in male pauper letters', in Gestrich, Hurren and King (eds), *Poverty and Sickness in Modern Europe*, pp.51-52.
[4] Fissell, pp.99-100
[5] A. Gestrich, E. Hurren and S. King, 'Narratives of poverty and sickness in Europe 1780-1938: Sources, methods and experiences', in Gestrich, Hurren and King (eds), *Poverty and Sickness in Modern Europe*, p.21.
[6] Tomkins, '"Labouring on a bed of sickness"', p.52.
[7] King, 'Poverty, Medicine', pp.229, 245; Gestrich, Hurren and King, 'Narratives of poverty and sickness in Europe', p.21; A. Negrine, 'Practitioners and Paupers', in Reinarz and Schwarz (eds), *Medicine and the Workhouse*, p.193.

progressed under the influence of the New Poor Law (hereafter NPL) enacted in 1834. Kevin Siena argues that medical historians have been slow to explore workhouses prior to the NPL and, as a result, they have not been integrated into the history of eighteenth-century institutional medicine.[8] Jeremy Boulton and Leonard Schwarz affirm that medical services provided by the parish workhouse under the Old Poor Law have been neglected within the study of institutional provision, despite delivering increasing amounts of medical care in the later part of the eighteenth century.[9] As a result, the traditional view that by the early nineteenth century there existed only a rudimentary medical service for the poor has prevailed. The relative neglect of poor law medicine by both medical and welfare historians continued into the nineteenth century and, according to Steven King, has meant that 'an understanding of the exact medical role of the workhouse remains elusive'.[10] Outdoor medical relief has received more attention than workhouse medicine since it played a larger part in the relief of the sick poor, partially due to the attempts by sick paupers to obtain alternative sources of support in order to avoid care in the workhouse. Furthermore, the majority of studies of the NPL institutional medical service have approached it as a vehicle for the development of state medicine and the rise of the National Health Service. Thus, further studies, utilising the available archival material, continue to be required. As John Stewart and King have pointed out: 'cumulative surveys of the historiography of the NPL have raised many questions about the operation and impact of poor law policy and emphasized just how much remains to be done in an empirical

[8] K. Siena, 'Contagion, Exclusion and the Unique Medical World of the Eighteenth-Century Workhouse', in Reinarz and Schwarz (eds), *Medicine and the Workhouse*, p.19.
[9] J. Boulton and L. Schwarz, 'The Medicalisation of a Parish Workhouse in Georgian Westminster: St Martin in the Fields, 1725-1824', *Family & Community History*, 17 (2014), pp.122, 130.
[10] King, 'Poverty, Medicine', p.230.

sense on the voluminous local and national archives.'[11] Moreover, research carried out in different geographical localities can lead to a greater understanding of the complexity of arrangements that grew up after the NPL.

This study will elucidate the character, scope and scale of medicine practised in the workhouse. By delineating the range and intensity of diseases suffered by sick inmates, it will bring to the fore a disadvantaged group, previously neglected by medical historians. It will add to the current understanding of NPL institutional medical care in a number of ways. Although the metropolis has dominated local and regional studies of workhouses and their infirmaries, provincial studies have managed to cover most geographical areas of England. The one major exception has been the urban west midlands, in which the workhouses of Birmingham and Wolverhampton are situated. The research into these two workhouses will aid in promoting the place of poor law infirmaries in the history of medical institutions, an under-researched area within medical history. It will highlight inmates with chronic disease and disability, a group that is difficult to identify within the workhouse classification system It will demonstrate how the division between acute and chronic hospitals took place as disabled inmates became to be regarded as not requiring medical care and were not moved from the workhouse into the separate infirmary in Birmingham. The role of workhouses in the control of epidemics and infectious disease has not previously been given prominence in the discourse of isolation institutions. This study will redress this deficiency, as well as highlighting the interrelationship between the poor law guardians and the sanitary and local authorities. By so doing, it will demonstrate the importance of the poor law institutions to the health of the communities they served.

[11] J. Stewart and S. King, 'Death in Llantrisant: Henry Williams and the New Poor Law in Wales', *Rural History*, 15 (2004), p.69.

An understanding of the day-to-day doctoring and nursing within the workhouse infirmary remains unclear and this study will address this issue of the 'reality of poor law doctoring'.[12] In the same manner, it will show what it was like to work as a nurse in the infirmary and that it was not dissimilar to nursing in voluntary hospitals. It will illuminate another unexplored area of medical practice in workhouses, by delineating the wide range of medical treatments that patients received, such as diet, drugs, alcohol and physical therapies, as well as listing the surgical operations that took place in these institutions. The research has unearthed a few letters written by former sick inmates, providing insight into patients' experiences and their perspective on the treatment they received in the workhouse, material that has not been previously available.[13] As a result, a more complex picture of the medical care within the workhouse will emerge. In summary, this chapter will challenge the traditional narrative of workhouse medicine as relevant only to the later development of state medical services and demonstrate that it was an important element of medical care for sick paupers in the nineteenth and early twentieth centuries.

[12] K. Price, 'A regional, quantitative and qualitative study of the employment, disciplining and discharging of workhouse medical officers of the New Poor Law throughout nineteenth-century England and Wales' (unpublished PhD thesis, Oxford Brookes University, 2008), pp.2, 326.
[13] A. Tomkins, 'Workhouse Medical Care from Working-Class Autobiographies, 1750-1834' in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse*, pp.99; E. C. Bosworth, 'Public Healthcare in Nottingham 1750-1911' (unpublished PhD thesis, University of Nottingham, 1998), p.209; D. R. Green, *Pauper Capital*, Farnham, 2010, p.238.

Methodology

The historiography of the social history of medicine has been influenced mainly by the introduction of sociological concepts and, more recently, by the cultural turn.[14] In promoting the social dimension within the history of medicine, Henry Sigerist wished to see history of medicine move away from the 'institutions and characters of medicine' to 'include the history of the patient in society and of the relations between physician and patient', as well as the impact of illness and medical institutions on people's lives. [15] American medical historians were at the forefront in the 1970s of this call to move away from the study of eminent physicians to those who remained unknown and to put patients at the centre of medical history studies. One important landmark in the move to this new social history was the publication in 1979 by Susan Reverby and David Rosner of *Health Care in America: Essays in Social History*. They wished to redefine the specialty as the history of health care that would focus on the social relations of medicine. They saw as the instrument of change, the influx of non-medical doctoral students who would engage in social histories of such issues as race, gender, class, politics and demography. The approach they sought was 'more as a social enterprise than as purely Scientific or celebratory one'.[16] This would contrast with, in their view, the dominance of physician-historians and their professional allegiances. As a result, the history of medical institutions, such as hospitals, has moved from being mostly written by the doctors who practised in them, detailing their progress, concentrating mostly on medical staff and rarely putting the account into a

[14] This development is covered in F. Huisman and J. H. Warner (eds), *Locating Medical History*, Baltimore, 2004; J. C. Burnham, *What is Medical History?*, Cambridge, 2005; M. Jackson (ed.), *The Oxford Handbook of the History of Medicine*, Oxford, 2011.
[15] Sigerist quoted in C. Webster, 'Historiography of Medicine' in P. Corsi and P. Weindling (eds), *Information Sources in the History of Science and Medicine*, London, 1983, p.39.
[16] S. M. Reverby and D. Rosner, '"Beyond the Great Doctors" Revisited', in Huisman and Warner (eds), *Locating Medical History*, pp.167-68, 173.

general historical framework. Now, systematic investigations by historians are ensuring that the social structure of the hospital and the position of managers, nurses, therapists and other ancillary staff, as well as patients are all being studied in order to understand the full nature of the institution, as experienced by all those who came into its ambit. Furthermore, institutional histories are made more relevant by setting them in the context of the life of the local community. Reverby and Rosner's book has been deemed a 'manifesto of the new social history movement in the history of American medicine' by later historians.[17] Around the same time, Anne Digby and Anne Crowther incorporated this approach into their histories of English workhouses.[18]

A further impact of the new social history has been the emphasis on the patients' perspective of the medical care they received and the interaction between patients and medical practitioners. Historian Mary Fissell describes this development succinctly: 'By starting with the patient, we arrive at an alternate version of the development of medical institutions and professional authority'.[19] The experience of medical care by the ordinary person, which had been ignored previously, was now the focus of research, but, as Digby has stressed, needed 'considerable interpretation and intervention by the historian to produce a synthesis' since a patient's experience could vary over time.[20] The work of Roy and Dorothy Porter has pioneered the writing of the history of medicine from the patient's point of view, emphasising the voice of the

[17] F. Huisman and J. H. Warner, 'Medical Histories' in Huisman and Warner (eds), *Locating Medical History*, p.21.
[18] Digby, *Pauper Palaces*; Crowther, *Workhouse System*.
[19] Fissell, p.14; her study, *Patients, Power and the Poor in Eighteenth-Century Bristol*, tracks the social development of health practice from medical marketplace to hospital-based medicine and its effect on the poor of taking away control of their own bodies.
[20] A. Digby, 'The Patient's View', in I. Loudon (ed.), *Western Medicine: an illustrated history*, Oxford, 1997, p.297.

individual patient.[21] However, their studies did not extend to institutional care. Guenter Risse and John Harley Warner have argued that institutional clinical patient records can reveal more than the course of an illness and its therapy. As surviving artefacts of the interaction between physicians and their patients, they throw light on patients' perceptions of illness and on their expectations of medical treatment.[22]

Patients' views were given an even more prominent place in medical historiography with the introduction of the new cultural history in the late 1980s and 1990s. The influence of the 'cultural turn' was to bring into medical history a new approach, which was 'self-reflective and conversational' and to allow for different perspectives and insights from other disciplines, particularly anthropology.[23] These are based around, as Fissell puts it, 'the making of meaning - to how people in the past made sense of their lives, the natural world, of social relations, of their bodies'.[24] Cultural history addresses ways in which individuals and groups express themselves and asks: 'How was it for him or her or them?'.[25] It has a predilection for the marginal and attempts to bring in members of social groups whose thoughts had not previously been considered of historical interest. A further benefit of such an approach has been greater consideration of the structure of medical historiography with a return to the narrative text. In the mid-1990s, there was a drift toward the re-introduction into the historical discourse of a social element without returning to the previous conventional social analysis. According to Roger Cooter, this synthesis of 'the social' and 'the

[21] A. Wear, 'Introduction', in A. Wear (ed.), *Medicine in Society*, p.4.
[22] G. Risse and J. H. Warner, 'Reconstructing Clinical Activities: Patient Records in Medical History', *Social History of Medicine,* 5 (1992), pp.189-90.
[23] M. Rubin 'What is Cultural History Now?' in D. Cannadine (ed.), *What is History Now*?, Basingstoke, 2002, pp.80-81.
[24] M. Fissell, 'Making Meaning from the Margins: The New Cultural History of Medicine' in Huisman and Warner (eds), pp.34-35.
[25] Rubin, p.81.

cultural' gives the opportunity to 'revisit old sites', which had been lost from the social history of medicine, and 'leaves the territory and the practice of the history of medicine wide open'.[26] The cultural turn has also led to an upsurge of focussed local studies and John Pickstone has stressed the additional benefit of comparative local studies in understanding medical dynamics as social history.[27] Furthermore, Barry Reay has demonstrated that microhistories can give rise to consideration of more general issues.[28] A further influence on medical historiography that took place in the twenty-first century was the exploration of the science in medicine and the subsequent adoption of the 'practice turn'.[29] This deals with the performative aspects of clinical practice as a basis for promoting a greater understanding of how medical knowledge influenced routine patient care.[30]

This study will be a qualitative and quantitative local micro-study examining and comparing the medical provision and care in the large workhouses in Birmingham and Wolverhampton in the West Midlands, both with rapidly expanding populations

[26] R. Cooter, '"Framing" the End of the Social History of Medicine', in Huisman and Warner (eds), p.328.
[27] J. V. Pickstone, 'Medicine in Industrial Britain: the Uses of Local Studies', *Social History of Medicine*, 2 (1989), pp.197-98. One of the earliest local studies was Marland, *Medicine and Society in Wakefield and Huddersfield 1780-1870*; more recent studies include: Stewart and King, 'Death in Llantrisant: Henry Williams and the New Poor Law in Wales'; A. N. Bergen, 'The Blind, the Deaf and the Halt' (unpublished PhD thesis, University of Leeds, 2004); S. Williams, 'Caring for the sick poor. Poor law nurses in Bedfordshire c. 1770-1834' in P. Lane, N. Raven and K. D. M. Snell (eds), *Women, Work and Wages in England, 1600-1850*, Woodbridge, 2004; S. King, 'Regional Patterns in the Treatment of the Sick Poor, 1800-40' *Family and Community History,* 10 (2007), pp.61-75; Negrine, 'Medicine and Poverty: A Study of the Poor Law Medical Services of the Leicester Union 1876-1914', (unpublished PhD thesis, University of Leicester, 2008); A. Tomkins, 'The Excellent Example of the Working Class: Medical Welfare, Contributory Funding and the North Staffordshire Infirmary from 1815', *Social History of Medicine*, 21 (2008), pp.13-30; D. Green, 'Icons of the New System: Workhouse Construction and Relief Practices in London under the Old and New Poor Law' *The London Journal,* 34 (2009), pp.264-84.
[28] B. Reay, *Microhistories: demography, society, and culture in rural England, 1800-1930*, Cambridge, 1996, p.xxii.
[29] M. Worboys, 'Practice and the Science of Medicine in the Nineteenth Century', *Isis*, 102 (2011), pp.110-12.
[30] J. H. Warner, 'The History of Science and the Science of Medicine', *Osiris*, 10 (1995), pp.189-90.

throughout the nineteenth century.[31] Birmingham parish workhouse was established in the early eighteenth century and provided a medical service to the town for almost 50 years prior to the erection of a voluntary hospital. It developed into one of the largest poor law institutions in England and toward the end of the nineteenth century its infirmary was separated geographically and administratively from the workhouse. In these respects, it was more in keeping with poor law institutions in London than average-sized provincial workhouses. It also resembled metropolitan workhouses in terms of its high institutionalisation rate with regard to paupers in general and older paupers in particular.[32] As a result, the practice of poor law medicine in Birmingham could be held to be atypical of provincial towns. The choice of Wolverhampton workhouse corrects this possible anomaly. Wolverhampton Union was established after the NPL, by the amalgamation of four parishes, and the union workhouse was a medium-sized institution in which the infirmary remained integral. In these ways, it was more typical of NPL urban workhouses and yet the community in which it was located was similar to Birmingham's.

The emphasis in the study is on adult physical medicine. Poor law records relating to the health of children are sparse as they dwell mainly on their educational requirements.[33] Furthermore children in Birmingham were moved to cottage homes, with medical facilities, in 1880 and those in Wolverhampton were transferred ten years later. Those with mental illness or disability as the sole diagnosis are not

[31] J. Vernon estimates that the populations of Birmingham and Wolverhampton increased tenfold between 1801 and 1931, in *Distant Strangers: How Britain Became Modern*, Berkeley, 2014, p.24.
[32] A. Ritch, 'English Poor Law Institutional Care for Older People: Identifying the "Aged and Infirm" and the "Sick" in Birmingham Workhouse, 1852-1912', *Social History of Medicine*, 27 (2014), pp.76-78; see Appendix L.
[33] The one study that has addressed the care of children in the workhouse is F. Crompton, *Workhouse Children,* although others which contain separate chapters or substantial sections on children include: Negrine, ' Medicine and Poverty'; N. Longmate, *The Workhouse*, London, 1974*;* Higgs, *Life in the Victorian and Edwardian Workhouse.*

covered, since 'lunatics, imbeciles and idiots' have been the subjects of more studies than other classes of pauper and because a lack of space within the word limit of the thesis would not allow full justice to be given to this group.[34] Because of rapid population expansion throughout the nineteenth century, the workhouses in both towns experienced continual overcrowding, which necessitated the erection of additional wards and buildings. Nevertheless, there were important differences in their approaches to the provision of poor law medical services. While Birmingham always provided separate facilities for sick inmates and employed nurses and a resident medical officer (hereafter MO), discrete sick wards and paid nurses were a later development in Wolverhampton, where MOs were employed on a part-time basis. Both institutions developed into large general hospitals in the early twentieth century, a role they continue to play today. The study starts in 1834 at the time of the Poor Law (Amendment) Act, although Wolverhampton Union was not formed until two years later. Birmingham continued as a Local Act Parish until it combined with two local unions in 1912 to form the large Birmingham Union and the use of the poor law buildings within the combined union was revised in a plan put forward by the medical superintendent the following year. However, war broke out before the re-organisation could take place and 1914 has thus been chosen as the end date for the period of study. This has the added advantage of not encroaching on the 100-year rule, which makes accessing archives more difficult. The main primary sources were the minutes of the board of guardians and its various committees. The minutes reflect

[34] L. Smith, 'The Pauper Lunatic Problem in the West Midlands, 1818-1850', *Midlands History*, 21 (1996), pp.106-13; A. Scull, *Museums of Madness: The Social Organisation of Insanity in Nineteenth-Century England*, London, 1979; A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900*, New Haven, 1993; J. Melling and B. Forsythe, *The Politics of Madness: The State, Insanity and Society in England, 1845-1914*, London, 2006; L. Smith, *Cure, Comfort and Safe Custody: Public Lunatic Asylums in Early Nineteenth-Century England*, Leicester, 1999; P. Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth–Century England*, London, 1999.

the guardians' primary concern with the management of poor law relief and entries could be limited to brief reports of issues discussed or merely a record of the outcome of debate. Birmingham usually recorded in detail letters and reports, whereas Wolverhampton only noted their receipt. However, Wolverhampton's meetings were reported in greater detail each week in the *Wolverhampton Chronicle*. Masters' journals elaborated on day-to-day events, but only one was available in each location and each covered only a few years. Matters concerning the sick were recorded sporadically, usually only at times when difficulties or complaints were experienced. Minutes of committees and sub-committees concerned with infirmary management were more helpful in this respect, but were only available from the late nineteenth century. The poor law minutes were supplemented by reports of the central authorities on poor relief and of parliamentary enquiries, by census reports, local newspapers and correspondence between the central authority and the boards of guardians, accessed at The National Archives.

Poor Law Historiography

The poor law administration gave rise to a massive archive of paperwork, but it contains little of the views and experiences of paupers themselves and even less in the case of pauper patients.[35] Felix Driver has pointed out that they survive only in 'fragmentary form, inevitably marked by the bureaucratic rituals of the system'.[36] Despite this lack of direct source material, Roy Porter considered that a variety of

[35] Crowther, *Workhouse System*, p.193; Driver, p.3; N. Goose, 'Workhouse Populations in the Mid-Nineteenth Century', *Local Population Studies*, 62 (1999), p.52. Despite a detailed study of the poor law medical service in Leicester, Negrine concluded that 'the views of the majority of patients on their medical treatment and care are mainly unknown', A. Negrine, 'Medicine and Poverty', p.126.
[36] Driver, p.3.

materials could yield information about patients' experiences, while Digby asserts that the use of the available records can strip paupers of their anonymity and bring out the significance of the poor law in human lives.[37] Recent studies have focussed on the experiences of the poor as found in pauper narratives.[38] They were written frequently to obtain medical relief and so offer new insights into the relationship between poverty and sickness. The contributors to a volume dedicated to pauper narratives, *Poverty and Sickness in Modern Europe*, have described the experiences of the dependent poor in a number of countries, but research to date has 'barely scratched the surface of the narrative material available'.[39] In addition, few letters were sent to institutions and none written by paupers resident in the workhouse have become available.[40] Further research may unearth letters from inmates, as this methodology is still in its early stages.[41] Risse and Warner contend that clinical records are a valuable source of 'medical experiences and perceptions of the past' and can help define the changing nature of clinical behaviour and practice.[42] As no routine recording of medical details was required within workhouse infirmaries, surviving poor law records are not a rich source of clinical information. Therefore, this study is less a 'history from below', than a social history, drawing out medical details and the experiences of inmates and patients where possible.

[37] R. Porter, 'The Patient's View: Doing Medical History from Below', *Theory and Society*, 14 (1985), p.183; Digby, *Pauper Palaces*, p.231.
[38] Gestrich, Hurren and King (eds), *Poverty and Sickness in Modern Europe;* Tomkins, 'Workhouse Medical Care', pp.86-102; King, 'Regional Patterns in the Experiences', pp.61-75.
[39] Gestrich, Hurren and King, 'Introduction', p.13.
[40] Ibid., pp.12, 24; Tomkins, 'Workhouse Medical Care', p.99.
[41] Gestrich, Hurren and King, 'Introduction', p.13.
[42] Risse and Warner, pp.183, 202.

Historian Ludmilla Jordanova has suggested that local studies are more likely to access such sources.[43] King has made the point that 'detailed local studies of poverty and the operation of the poor laws have been notable for their absence' and that the systematic local study is uncommon.[44] Nigel Goose is in agreement when he draws attention to the lack of studies which are 'firmly rooted within the local or regional economic and social context' and the 'specific circumstances of local communities'.[45] Intensive local studies can contribute to the general understanding of the character of the poor laws, as considerable local control over poor law administration led to wide variability in implementation throughout England. Also, they can reveal hidden complexities, which can supersede a broader picture.[46] Digby's regional study of workhouses in Norfolk was one of the first to demonstrate how local perspectives have been valuable in creating a more balanced national picture and she maintains that more such studies could supply 'valuable additional information on poor law topography'.[47] Local studies of poor law medical services have been carried out by Angela Negrine in Leicester and Ennis Bosworth in Nottingham.[48] Both conclude that a genuine effort was made to provide good standards of medical care for most of the time and that considerate treatment was often provided. However, they consider that it is difficult to evaluate the quality of care when the attitude and views of patients are missing from the records.[49] More recently, Graham Butler has carried out an analysis of the institutional and medical responses to sickness and disease in

[43] L. Jordanova, 'Has the Social History of Medicine Come of Age?' *Historical Journal*, 36 (1993), p.441.
[44] King, p.4.
[45] Goose, p.52.
[46] Tomkins, *Experience of Urban Poverty*, p.235.
[47] Digby, *Pauper Palaces*, p.232. This view is supported by Negrine, p.322; King, *Poverty and Welfare*, p.4; Jordanova, p.441; Rose, p.4; Driver, pp.73-74; Kidd, p.46.
[48] Negrine, 'Medicine and Poverty: A Study of the Poor Law Medical Services of the Leicester Union 1876-1914' ; Bosworth, 'Public Healthcare in Nottingham 1750-1911' (unpublished PhD thesis, University of Nottingham, 1998).
[49] Negrine, p.236; Bosworth, p.269.

Newcastle-upon-Tyne between 1750 and 1850.[50] He found that workhouse medicine was an important element within the medical response to sickness in this industrial city and was more complex than has been described in other provincial workhouses.[51] However, microstudies relating to the sick poor remain relatively uncommon across Europe and few have investigated the attitude of paupers to their illnesses or to medical officials.[52] The recent trend in poor law historiography has been to stress diversity and regionalism. King has questioned whether England had a single welfare system under the NPL, rather than a number of 'coalescing' systems, whereas Alan Kidd is more dogmatic that there never was a 'national poor law'.[53] However, he has cautioned against the temptation to make generalisations suggesting a uniform welfare system from a few local or regional studies.[54] Within local or regional historiography, the workhouses of the large provincial cities have been neglected, particularly those with rapidly expanding populations in the early nineteenth century as a result of industrialisation.[55] London's poor law institutions have received extensive scrutiny, but its medical welfare system has been described as so dissimilar to other major English cities as to be 'something of an oddity'.[56] David Green's study of the poor laws in the capital has confirmed its heavy reliance on indoor relief and high rates of pauperism.[57] Michael Rose's contention that the recent historiography of the nineteen-century poor law has a rural bias would account for the paucity of studies of

[50] G. A. Butler, 'Disease, Medicine and the Urban Poor in Newcastle-upon-Tyne, c. 1750-1850' (unpublished PhD thesis, Newcastle University, 2012).
[51] Ibid., pp.270-72.
[52] Gestrich, Hurren and King, 'Introduction', p.23.
[53] King, *Poverty and Welfare*, p.10; Kidd, p.46.
[54] Kidd, pp.18, 30.
[55] There have been studies carried out of smaller industrial cities and towns, for example, Negrine in Leicester; Marland in Wakefield and Huddersfield; P. Wood, 'Finance and the urban poor law: Sunderland Union 1836-1914', in M. E. Rose (ed.), *The poor and the city: the English poor law in its urban context, 1834-1914*, Leicester, 1985, in Sunderland; Driver in Huddersfield; Fissell in Bristol.
[56] King, *Poverty and Welfare*, p.13.
[57] D. Green, *Pauper Capital*, Farnham, 2010, pp.38, 153, 191-92.

provincial urban workhouses.[58] Although institutional histories are plentiful within medical historiography, many have been of the celebratory type and workhouse infirmaries have been relatively neglected compared with the more prestigious voluntary and charitable hospitals.[59] Nevertheless, histories of the workhouse have been one of the main approaches used to reach an understanding of the character and role of the poor law welfare system.[60]

The New Poor Law and the Workhouse

The main objective of the NPL was the control of rising unemployment and vagrancy among able-bodied adults. The Royal Commission on the Poor Laws, which preceded it, has come under criticism from historians for incorrectly diagnosing the reasons for the increase in expenditure on poor relief.[61] The act of 1834 established the principles of deterrence and rigid centralisation, designed for the management of pauperism in order to control the 'unacceptably burdensome poor rates'.[62] It attempted to limit outdoor relief other than medical attention, by requiring every parish and union to provide institutions for paupers. The original intention of separate buildings for different types or classes of pauper never materialised and the general mixed workhouse gradually predominated across the country. It became the central

[58] Rose, p.4.
[59] Examples include J. Woodward, *To Do the Sick No Harm: A Study of the British Voluntary Hospital System to 1875*, London, 1974; K. Waddington, *Charity and the London Hospitals 1850-98*; J. V. Pickstone, *Medicine and Industrial Society: a history of hospital development in Manchester and its regions 1752-1946*; J. Reinarz, *Health Care in Birmingham: The Birmingham Teaching Hospitals 1779-1939*, Woodbridge, 2009.
[60] King, p.3.
[61] S. Webb and B. Webb, *Minority Report of the Poor Law Commission*, Clifton, 1909, p.3; Hodgkinson, p.1; Digby, *Pauper Palaces*, p.107; Driver, p.23; A. Digby, *The Poor Law in Nineteenth-century England and Wales*, London, 1982, pp.9, 13; Crowther, *Workhouse System*, p.271.
[62] Driver, p.3; Digby, *The Poor Law*, p.9.

component of poor law policy after 1834 and its layout and appearance were designed to make a powerful impact on the poor.[63] The act also established the principles of 'less eligibility' for relief and of a lower standard of living for a pauper compared to a wage-earning labourer. It promoted the 'workhouse test', whereby a pauper would only receive relief if prepared to enter a workhouse, where conditions would theoretically have been worse than for the poorest in the community. The workhouse test was intended as a means of distinguishing those who were destitute from those who were seen as merely poor, in order to reduce expenditure from the poor law rates. The enforcement of less-eligibility could only be achieved by psychological means, namely deprivation of identity and dignity.[64] According to Driver, the workhouse was 'designed to be a disciplinary institution, its inmates subject to the rule of official regulations'.[65] Crowther describes the subsequent rapid development of centrally administered, heavily regulated workhouses as the 'first national experiment in institutional care'.[66]

The majority of accounts of the workhouse system are in agreement that it depended on the classification of paupers, with complete segregation of all classes, of men from women and adults from children, with emphasis on strict discipline and monotonous daily routine in which the same activities took place at the same times each day.[67] Paupers were supplied with the uniform in use in the workhouse they entered and their own clothes were returned to them on discharge. The dietaries were repetitive, the food was often adulterated and dietary restriction played a major role in the disciplinary system. One of the most important aspects was the reliance on the

[63] Driver, p.147; King, p.3; K. Morrison, *The Workhouse,* Swindon, 1999, pp. 43, 54.
[64] Kidd, pp.34-35.
[65] Driver, p.64.
[66] Crowther, *Workhouse System*, p.3.
[67] Crowther, *Workhouse System*, pp.193-221; Higgs, pp.18-21.

surveillance of individual conduct, as was common in projects of moral regulation in the nineteenth century. Discipline was instilled into the inmates by regimentation and regulating every minute of the day.[68]

The principles of the workhouse system had a direct influence on the structure and design of the new union workhouses. Furthermore, the changes in the architectural structure over the second half of the nineteenth century reflected the prevailing attitudes to poverty, the directions of the central authorities and the type and class of pauper for which the accommodation was intended. The effectiveness of the system as a deterrent depended upon ensuring strict physical segregation of the different classes of pauper within the building.[69] The grouping of parishes into larger unions meant that buildings of a considerable size were required and their forbidding appearance and disciplinary regime were intended to impress on the poor the virtues of 'independent' labour.[70] They enhanced the sense of depersonalisation by diminishing the more personal contact between paupers and poor law officers that had been usual in the parishes. Many workhouses provided sick rooms or wards for inmates who were unwell and larger ones often had designated infirmaries. The Metropolitan Poor Act of 1867 was the stimulus for the erection of separate poor law infirmaries throughout London, managed independently from the workhouses. Outside the metropolis, separately managed facilities for the sick were only likely to be found in the large workhouses of the industrial cities. Ruth Hodgkinson is of the

[68] Driver, p.10; Lees, p.147; this system has been likened to the regulation of the lives of citizens in Thomas More's *Utopia*, published in 1516, see P. Spierenburg, 'Four Centuries of Prison History' in N. Finzsch and R. Jütte (eds), *Institutions of Confinement*, New York, 1996, p.21.
[69] Morrison, p.43.
[70] Driver, p.71.

opinion that most of the reforms to establish separate treatment for the sick had taken place by 1871.[71]

One of the earliest social histories of the workhouse was published in 1974 by Norman Longmate.[72] The tone of his study is set by his early statement that the purpose of the workhouse was to terrorise the poor and he could remember it as a child being 'feared and hated'.[73] Similar comments appear in later accounts. For instance, Michelle Higgs is of the opinion that the fear of the workhouse became an integral part of workhouse mythology, and Simon Fowler questions why workhouses were detested so much by those who had to use them.[74] However, Digby cautions that this view of the workhouse reflects popular mythology more than historical reality and that the conception generally held today of workhouse life places too great a reliance on a relatively small number of adverse reports.[75] Her study of the workhouses in Norfolk, *Pauper Palaces*, instigated a difference of opinion regarding the quality of poor law institutional care within the historiography of the workhouse. In *The Workhouse System 1834-1929*, a comprehensive analysis of the poor laws and the working of the workhouse, Crowther also offers a more balanced picture. She describes the workhouse as invariably a place of irresolvable tension by attempting to be both a place for deterring able-bodied paupers while a refuge for the old and the sick.[76] She emphasises the variability and diversity within parishes, where the

[71] Hodgkinson, pp.686-88.
[72] Longmate, *The Workhouse*, London, 1974.
[73] Ibid., pp.11-12.
[74] Higgs, p.9; Fowler, p.7.
[75] Digby, *Pauper Palaces*, pp.ix, 177.
[76] Crowther, *Workhouse System*, p.3.

conditions in workhouses were influenced by the size of the union, the wealth of local ratepayers, the calibre of the local guardians and the activity of pressure groups.[77]

There are conflicting views over how effective the workhouse was as a deterrent toward those seeking relief. Both national statistics and those from a London Union reveal considerable activity of entry and discharge, even among older men. It is possible that the unskilled working class may have used the workhouse for their own purposes, when it suited them, without any fear of disgrace.[78] Although conditions improved toward the end of the nineteenth century, the dreariness within the institution remained and the real stigma attached to entering the workhouse may have been that of associating with the 'disreputable poor'.[79] Such close contact with those deemed 'undesirable' would have had a deterrent effect, particularly on older people, who constituted a large and important group of inmates, but one that has been relatively neglected within workhouse records. Crowther has pointed out that no regular census of inmates by age group took place prior to 1913, though she cites the finding of the Royal Commission on the Aged Poor, stating that 46.5% receiving poor law relief were over 60 years of age and nearly half were in workhouses.[80] However, the main concern of the Royal Commission in 1834 was the increase in the number of able-bodied paupers and it only gave brief mention to older paupers, as old age was not recognised as a social problem.[81] It did accept 'aged and impotent persons' as 'proper objects of relief and expected that they would accept the workhouse as 'a

[77] Ibid., p.6.
[78] Ibid., pp.228-31.
[79] Ibid., pp.239-40.
[80] M. A. Crowther, 'The Later Years of the Workhouse', in P. Thane (ed.), *The Origins of British Social Policy*, London, 1978, pp.44-45.
[81] Kidd, pp.39-40.

place of comparative comfort'.[82] The first annual report of the PLCs classified indoor paupers into seven groups, separating men and women and dividing both into either able-bodied or 'aged and infirm'; the latter were previously known as the 'impotent poor'.[83]

Throughout the nineteenth century, the proportion of those aged over 60 years remained between seven and eight per cent of the population of England and Wales.[84] The percentages of the population aged 65 and over in poor law institutions showed a steady increase from about 13% in 1851 to about 23% in 1901, although the proportion declined to 20% in 1911, similar to the level found in 1891.[85] By 1891, one-third of workhouse inmates were aged 65 and over, although only a small proportion of the population over the age of 65 entered workhouses.[86] Nevertheless, they formed the second largest group of inmates after children in workhouse populations in the mid-nineteenth century and, in time, the workhouse became 'the institution of the aged'.[87] Relatively little has been recorded in respect of older paupers who were sick and disabled, because of the difficulty of identifying them within the poor law records and of differentiating between those requiring medical treatment and those needing social care.[88] Age-related rationing of medical care was

[82] S. G. Checkland and E. O. A. Checkland (eds), *The Poor Law Report of 1834*, Harmondsworth, 1974, pp.338, 425.
[83] British Parliamentary Papers (hereafter BPP), 1835 (500), p.60.
[84] Smith 'The Structured Dependence of the Elderly as a Recent Development', *Ageing and Society*, 4 (1984), p.414; Laslett 'The Significance of the Past in the Study of Ageing' *Ageing and Society*, 4 (1984), p.382.
[85] D. Thomson, 'Workhouse to Nursing Home: Residential care of elderly people in England since 1840', *Ageing and Society*, 3 (1983), p.49.
[86] Ibid., pp.46-47.
[87] Ibid.
[88] P. Thane, 'Geriatrics', in W. F. Bynum and R. Porter (eds), *Companion Encyclopaedia of the History of Medicine*, London, 1993, p.1109; M. Martin, 'Medical Knowledge and Medical Practice: Geriatric Medicine in the 1950s', *Social History of Medicine*, 7 (1995), pp.458-59; Digby, *Pauper Palaces* pp.162-64; P. Townsend, *The Last Refuge*, London, 1962, p.23. For an in-depth account of older disabled inmates, see A. Ritch, English Poor Law Institutional Care for Older People: Identifying the

prevalent in the nineteenth century and sick older people were frequently refused admission to voluntary hospitals, as they were considered to be suffering from chronic or incurable diseases.[89] As this discrimination extended to Shoreditch Workhouse Infirmary, Claudia Edwards has suggested that poor law medical care for 'the elderly' may have been less generous than some historians have suggested.[90]

Provision for Sick Inmates

Prior to 1834, sick inmates frequently remained in their beds within the workhouse dormitories. Only larger workhouses provided sick rooms or wards for inmates who became unwell, while very few had designated infirmaries. Sick wards were included in the plans of the model workhouses included in the first annual report of the PLCs and one type involved an infirmary in a separate building sited to the rear of the main workhouse.[91] Dedicated infirmaries, consisting of a number of small rooms, became more popular by the 1860s and, at times, were located in sites at a distance from the workhouse, especially in London. In the later nineteenth century, many adopted the pavilion style, praised by Florence Nightingale, which allowed a high degree of segregation and through-ward ventilation. As workhouses catered for the chronic sick on a long-term basis, this necessitated provision of large infirmaries and the

'Aged and Infirm' and the 'Sick' in Birmingham Workhouse, 1852-1912', *Social History of Medicine*, 27 (2014), pp.64-85.

[89] T. R. Cole and C. Edwards, 'The 19th Century', in P. Thane (ed.), *The Long History of Old Age*, London, 2005, p.233; Woodward, p.45; B. Abel-Smith, *The Hospitals, 1800-1948*, London, 1964, pp.206-7.

[90] C. Edwards, 'Age-based rationing of medical care in nineteenth-century England', *Community and Change*, 14, 2 (1999), p.251.

[91] Morrison, p.69.

recommended size of 500 to 600 beds was often exceeded. By 1900, some had expanded to over 1,000 beds.[92]

A significant step in the development of infirmaries was the passing of the MPA in 1867. By the 1840s, a movement for workhouse reform developed, stimulated by reports of insanitary and overcrowded conditions and scandals involving the deaths of paupers. *The Lancet* commissioned workhouse surveys and one of its commissioners, Dr Ernest Hart, outlined the reformers' demands in an article which he entitled *The Condition of Our State Hospitals*, a term he used to describe the infirmaries of the workhouse.[93] The resultant MPA established, in London, separate asylums for lunatics and imbeciles, institutions for isolation of those with infectious diseases and dispensaries for outdoor medical relief. Thus, a system of medical care, with both inpatient and outpatient facilities, was instigated. It recommended resident medical officers with one to every 150 patients. The result was that, by 1888, there was hardly one union in the capital without a separate infirmary.[94] The act represented an explicit acknowledgement by the state of its responsibilities for the destitute sick.[95] A common fund was established to pool the poor law levies and all parishes and unions were combined into one district, the Metropolitan Asylum District, under the control of one board. The result was a centralised hospital system and the President of the Poor Law Board (hereafter PLB) had, in effect, signed 'the birth certificate of England's first regional hospital board'.[96] The inauguration of state hospital services for the poor in London represented, in Gwendoline Ayer's view, 'a significant step

[92] Ibid., p.171.
[93] E. Hart, 'The Condition of our State Hospitals', *Fortnightly Review*, III (1885), p.218.
[94] Hodgkinson, p.521.
[95] G. M. Ayers, *England's First State Hospitals and the Metropolitan Asylums Board*, London, 1971, p.17.
[96] Ibid., p.28.

towards socialisation of medical care in this country', and Frederick Cartwright was of the opinion that it was 'the first step towards a National Health Service'.[97] From this time, demands began to arise for the state to intervene directly in health care and take responsibility for social and economic conditions of the population with the result that appropriate government measures steadily increased.[98] In the same year, the principles of the act were extended to the whole country, so beginning the process of taking hospitals out of workhouses and firmly establishing the hospital branch of the poor law. These separate infirmaries began to be selective in admitting only those with acute illness, leaving the workhouses to accept the remainder, who were predominantly the chronic sick. Hodgkinson considers this differentiation between the two types of admission was in place by 1871.[99] Fowler has described the development of poor law medical care as the 'greatest success of the workhouse'.[100] Nevertheless, as Alysa Levene has pointed out, the state of affairs by the time of the Local Government Act in 1929 was a 'patchwork of local provision and uneven services in medical care for the poor'.[101]

The NPL made no recommendations for a medical service and the PLCs never envisaged that acute illness would be a reason for admission. However, medical relief became an increasingly frequent reason for admission to the workhouse. Sickness has been viewed traditionally as a major cause of poverty by restricting earning power, but more recent insights into the relationship between poverty and sickness have

[97] Ibid; F. F. Cartwright, *A Social History of Medicine*, London, 1977, p.159.
[98] P. Thane, *Foundations of the Welfare State*, London, 1982, p.vii; C. Webster, *The National Health Service*, Oxford, 1998, p.2; D. Fraser, *The Evolution of the British Welfare State*, Basingstoke, 2003, p.148.
[99] Ibid., p.545.
[100] Ibid., p.64; Longmate, p.194; Fowler, p.150.
[101] A. Levene, 'Between Less Eligibility and the NHS: The Changing Place of Poor Law Hospitals in England and Wales, 1929-39', *Twentieth Century British History*, 20 (2009), p.323.

shown that the poor were more likely to suffer ill health.[102] Sick inmates formed a substantial group within the workhouse population, from 10% in 1847 to 30% in 1867.[103] It is likely they remained around this proportion into the early twentieth century as, in 1915, 32% of inmates of poor law institutions were accommodated in sick wards or separate infirmaries.[104] Poor law institutions provided 81% of the country's hospital beds by 1861, so it is not surprising that, ten years later, some workhouses could be described as the 'first public hospitals' and those in the larger towns as 'infirmaries for the sick'.[105] This trend has led to claims by some historians that the medical service was the great success of the NPL, on the basis that it improved and widened the range of medical facilities and laid the foundation for the development of the National Health Service in 1948.[106] Alternatively, other welfare historians maintain that medical care declined immediately after the implementation of the NPL. Funding was restricted, sick inmates were subjected to the harsh workhouse regime, infirmaries were under-staffed and MOs frequently undermined by guardians over the treatment of patients.[107] However, there is more agreement that it did improve in the later part of the nineteenth century.[108]

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[102] Gestrich, Hurren and King (eds), p.24; Tomkins, '"Labouring on a bed of sickness"', p.52**.** Health inequalities were first reported in the Black Report in 1980 (published in P. Townsend and M. Davidson (eds), *Inequalities in Health*, London, 1988) and received more detailed analysis in R. G. Wilkinson, *Unhealthy Societies*, London, 1996.
[103] Hodgkinson, pp.147, 467.
[104] Crowther, *Workhouse System*, p.89.
[105] D. Fraser, *Evolution of the British Welfare State*, Basingstoke 2003, p.100; Hodgkinson, p.451; D. Ashforth, 'The Urban Poor Law', in Fraser (ed.), *The New Poor Law in the Nineteenth Century*, p.148.
[106] Hodgkinson, pp.64, 696; Fowler, p.150; Flinn, pp.48-49, 66; I. Loudon, 'Medical Practitioners 1750-1850 and the period of medical reform in Britain', in A. Wear (ed.), *Medicine in Society*, Cambridge, 1992, pp.220, 246; Marland, p.70; Longmate, p.194.
[107] Price, pp.266, 339, 345; Marland, p.93; A. Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911*, Cambridge, 1994, p.244.
[108] Crowther, *Workhouse System*, pp.160-62; A. Tomkins, 'The Excellent Example of the Working Class: Medical Welfare, Contributory Funding and the North Staffordshire Infirmary from 1815', *Social History of Medicine,* 21 (2008), p.14; Digby, *Pauper Palaces*, pp.168-69; Brand, *Doctors and the State*, p.86.

The PLCs did not initially intend that a test of need should be applied to sick, disabled and older paupers, but their Seventh Annual Report in 1841 did extend the principles of less-eligibility and deterrence to those seeking medical relief and this was given further emphasis in the Longley Report in 1874.[109] As a result, paupers admitted to the workhouse because of sickness or disability were subjected to the workhouse test and to the same regime within the institution as all other inmates. Their one concession was a special dietary to provide a better standard of nutrition.[110] In the late 1860s, the PLB reversed the policy of less-eligibility in relation to the sick, and its president, the Conservative politician, Gathorne Hardy, declared that the deterrent principle was no longer appropriate. Despite this, many provincial unions were slow to implement the change and in Birmingham and Manchester the sick were still subjected to the workhouse test in 1888.[111] According to Jeanne Brand, the medical care of paupers remained 'hedged with a persuasive atmosphere of deterrence' and Jonathan Reinarz and Leonard Schwarz remind us that workhouses 'retained both their medical and punitive functions'.[112]

Medical Care in the Workhouse

There has been a lack of research on the nature and role of the medical care offered within urban workhouses; a lack that this study seeks to redress. Furthermore, much of the historiography of workhouse medicine has focussed on specific areas, such as mental illness, contagious disease during epidemics or on specific groups, such as

[109] King, *Poverty and Welfare*, p.29; Hodgkinson, p.60; Williams, p.97.
[110] Higgs, p.72.
[111] Webb and Webb, *English Poor Law History*, pp.319-20; Flinn, p.65; Hodgkinson, p.542; J. Brand, 'The Parish Doctor', *Bulletin of the History of Medicine*, 35 (1961), p.110.
[112] Brand, 'The Parish Doctor', p.98; Reinarz and Schwarz, p.4.

those with venereal disease, rather than the full range of physical disease and disability within the institution and its infirmary, as is proposed in this study. Within the historiography of poor law medicine, the emphasis has been on the medical profession and the professionalisation of its MOs to the neglect of local medical practice. The history of Battle Workhouse by Margaret Railton and Marshall Barr is one of the few detailed studies of medical care in a poor law institution, but is basically a developmental account of its transition into a general hospital.[113] A regional perspective of poor law medical services is covered in Pickstone's description of all types of medical institutions in the Manchester region. It deals with the complex interrelationship between the hospitals and their communities and concludes that comparative urban history has much to offer in elucidating the determinants of medical services.[114] In a study of Shrewsbury hospital in the eighteenth century, Tomkins demonstrates that paupers who were admitted had a different experience to other patients, in particular a much higher death rate.[115] Green has outlined the development of poor law institutions in London and how they served as a basis for the state's responsibility for the health care of its citizens. Nevertheless, he highlights how medical relief was an important element of poor law policy in the metropolis, with around 15% of inmates classed as sick, compared with just over 10% in the provinces.[116] Jeremy Boulton, Romola Davenport and Leonard Schwarz provide a local study of a London workhouse, St Martin in the Fields, concentrating on mortality rates, which were high due to the admission of patients who were very young, very old or in a dying state. However, they include descriptions of individual

[113] M. Railton and M. Barr, *Battle Workhouse and Hospital 1867-2005*, Reading, 2005.
[114] Pickstone, p.2.
[115] A. Tomkins, 'Paupers and the Infirmary in Mid-eighteenth-century Shrewsbury', *Medical History*, 43 (1999), pp.208-27.
[116] D. Green, 'Medical Relief and the New Poor Law in London', in O. P. Grell, A. Cunningham and R. Jütte (eds), *Health Care and Poor Relief in 18th and 19th Century Northern Europe*, Aldershot, 2002 pp.226-27, 240.

patients' experiences of illness.[117] Their chapter is included in the most recently published volume on medical aspects of the poor law, *Medicine and the Workhouse*.[118] Although the contributions focus on care within the workhouse, most include consideration of outdoor medical relief because of the close inter-relationship between the two types of relief. Many authors concentrate on distinct groups within the workhouse such as older inmates, patients with venereal disease, children and epileptics. Although considerable new evidence is presented, the volume draws out the need for additional microstudies of workhouses, especially under the NPL.[119] Consequently, there is a continuing need for intensive local exploration of the nature of medical practice and the setting in which it took place, in order that new insights and interpretations may lead to a better understanding of the poor law medical service.[120]

Poor Law Medical Officers

The most detailed and extensive review of the medical services of the NPL is *The Origins of the National Health Service* by Hodgkinson.[121] Derek Fraser considers its value has been diminished because the study is so voluminous and remorseless in pursuit of detail and its scope is limited to the early period of the NPL.[122] It charts the progress made toward competent nursing and qualified medical personnel and details

[117] J. Boulton, R. Davenport and L. Schwarz, '"These ANTE-CHAMBERS OF THE GRAVE"? Mortality, Medicine and the Workhouse in Georgian London, 1725-1824', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse*, Rochester, 2013, pp.58-85.
[118] J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse*, Rochester, 2013.
[119] Ibid., p.11.
[120] Negrine, 'Medicine and Poverty', pp.1-3.
[121] R. G. Hodgkinson, *The Origins of the National Health Service: the Medical Services of the New Poor Law 1834-47*, London, 1967.
[122] D. Fraser, 'Biographical Notes', in D. Fraser, *The New Poor Law*, pp.197-98.

the poor law MOs' demands for professional standards. However, only a few piecemeal improvements were belatedly achieved. There were increasing pressures for MOs to admit the sick to institutions rather than provide domiciliary care. These included the condition of the person's home, the degree of family support, the workload of the doctor and whether he could provide adequate drugs out of his meagre salary. One important development by the late 1860s was the establishment of workhouse medical officers (hereafter WMOs), most of whom only had duties in the institution and some of whom were resident. Most workhouses had one MO, though in London it was often two. Guardians also employed the services of visiting physicians and surgeons to attend to the needs of sick inmates. Hodgkinson considers that institutional medical relief was humane by the standards of the time, whereas Kim Price is of the opinion that understaffing resulted in a failure to provide basic care.[123] According to Stewart and King, the conflict that existed in many unions between guardians and MOs was unlikely to lead to effective or conscientious medical care.[124] What is clear is that the standard of poor law medical care varied greatly throughout the country, although there is some indication that better conditions may have existed in the larger industrial cities.[125]

In Victorian England, the social status of poor law MOs was low, both within the medical profession, where they were regarded as third-rate practitioners, and the poor law administration, where guardians treated them as servants. The main reasons for this were that they were poorly paid, worked for a state service and treated patients

[123] Hodgkinson, p.129; Price, p.237.
[124] Stewart and King, p.81.
[125] Rose, pp.169-71; Crowther, 'The Later Years', p.50; Brand, *Doctors and the State*, p.96.

who were destitute.[126] Their workload was immense, for instance, *The Lancet* commented in 1867 that Bethnal Green Workhouse had only one for 600 patients, while a similar sized voluntary hospital in London would have had 15 doctors.[127] Pressure at national level achieved little as the central authority remained reluctant to become involved in medical matters and most of the problems remained unresolved throughout the existence of the poor laws.[128] By 1871, poor law MOs were seen as an important branch of the medical profession and their status within the profession had risen. Within the workhouse, it gradually changed from a subordinate role to one of great influence by 1914.[129] Nevertheless, Crowther considers that they remained at the bottom of the medical hierarchy.[130]

They were in the forefront of the pressure to reform the service, but there is controversy among historians as to their motivations and achievements. This ranged from the view that they had little success and the improvements they demanded would only have benefited their own interests to Hodgkinson's assertion that the improvements they achieved furthered the interests of their patients.[131] She considers that poor law MOs stand out as 'particularly good public servants', striving for 'positive health measures', and Brand concurs that they repeatedly urged for improvements in medical care to the poor.[132] Instances of WMOs carrying out innovative procedures, particularly in surgery, have been recorded in the literature.[133]

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[126] Crowther, *Workhouse System*, pp.167, 181; M. A. Crowther, 'Paupers or Patients?', *Journal of History of Medicine and Allied Sciences*, 39 (1984), pp.33-34, 53; Brand, *Doctors and the State,* p.85.
[127] Hodgkinson, p.356.
[128] Flinn, p.61.
[129] Crowther*, Workhouse System,* p.173; Brand, *Doctors and the State*, p.88.
[130] Crowther, *Workhouse System*, p.167.
[131] Crowther, 'Paupers or Patients?', p.37; Brand, *Doctors and the State,* p.234; Hodgkinson, pp.680-82.
[132] Hodgkinson, pp.xv-xvi; Brand, *Doctors and the State*, p.234.
[133] Flinn, p.61; R. G. Hodgkinson, 'Poor Law Medical Officers of England, 1834-1871', *Journal of History of Medicine and Allied Sciences*, XI (1956), p.312; Negrine, 'Medicine and Poverty', p.232.

Crowther considered that they were not in a position to make more than minor changes, but she concedes that little was known about the situation of local doctors.[134] Alternatively, Michael Flinn contended that individual MOs brought about piecemeal improvements locally by means of 'perpetual guerrilla warfare'.[135] Price describes poor law MOs as a 'fractious heterogeneous group' with only a few as 'prescient reformers'. He considers the historiography of these medical men to be contradictory and incomplete, especially with regard to the nature of their day-to-day practice; what he refers to as the 'reality of poor law doctoring'.[136] Nevertheless, there is general agreement among historians that poor law MOs were the key figures in the poor law medical welfare system, and Lynn Hollen Lees asserts that they 'turned paupers into patients'.[137] This detailed, intensive local study of two workhouses provides the opportunity to determine whether local WMOs were able to bring about improvements in patient care and introduce new forms of treatment.

Workhouse Nursing Care

The historiography of the nursing profession prior to 1980 has been written for the most part as a conventional, congratulatory discourse and only since the late 1980s has it developed into a more critical and reflective area of scholarship. The major exception is Brian Abel-Smith's *A History of the Nursing Profession,* published in 1960, although it dealt primarily with the structure of the profession, rather than

[134] Crowther, 'Paupers or Patients?', p.53.
[135] Flinn, p.61.
[136] Price, pp.2, 336.
[137] Lees, p.279.

nursing as an activity and what it was like to perform nursing tasks.[138] Celia Davies' 'mould-breaking', edited collection in 1980 exhibited a more reflective narrative and set up a revolution through the writing of nursing history over the next decade.[139] The most recent accounts place the history of nursing within a wider historical context and focus on the reality of practising as a nurse in the nineteenth century and the nature of the women who chose to be nurses.[140] Little research has been carried out on the period before the nineteenth century or in its early decades.[141] The majority of the literature has concentrated on the reforms since then in terms of the development of training according to the Florence Nightingale School, established in 1860. However, there were earlier initiatives to offer training to nurses, one of which was the Institution of Nursing Sisters, set up by the Quaker philanthropist, Elizabeth Fry, in 1842. The Institute's nurses gained experience by means of short attachments in London voluntary hospitals. Thereafter, the majority went into private practice.[142] Fourteen years later, the Anglican Sisters of St John's House spearheaded reform of hospital nursing in England. They devised a system of training and took over the nursing at King's College Hospital, London.[143] On Nightingale's return from Crimea in 1856, a national appeal raised sufficient funds to establish a training institution for nurses. Four years later, the first probationers from the school arrived at St Thomas'

[138] C. Davies (ed.), *Rewriting Nursing History,* London, 1980, pp. 11-14; A. M. Rafferty, J. Robinson and R. Elkan (eds), *Nursing history and the politics of welfare*, London, 1997, pp. 1-3; B. Abel-Smith, *A History of the Nursing Profession*, London, 1960, p.xi.
[139] Davies, *Rewriting Nursing History*; Rafferty, Robinson and Elkan, pp.1-2.
[140] C. Hawkins, *Nursing and Women's Labour in the Nineteenth Century*, Abingdon, Oxon, 2010; A. Borsay and B. Hunter (eds), *Nursing and Midwifery in Britain since 1700*, Basingstoke, 2012.
[141] S. Williams, 'Caring for the sick poor; poor law nurses in Bedfordshire c. 1770-1834', in P. Lane, N. Raven and K. D. M. Snell (eds), *Women, Work and Wages in England, 1600-1850*, Woodbridge, 2004, p.142. One of the few is C. Helmstadter and J. Godden, *Nursing before Nightingale, 1815-1899*, Farnham, 2011.
[142] Helmstadter and Godden, pp.72-73.
[143] Ibid., p.123.

Hospital, London.[144] Although the Nightingale School achieved little in its first 10 years, the surrounding publicity encouraged other hospitals to copy the system. Additionally, the School attracted motivated recruits, who carried the banner elsewhere.[145] Throughout the second half of the nineteenth century, nursing developed as a profession and nursing registration was eventually achieved in 1919.

The dominance of the Nightingale reforms in nursing historiography has overshadowed improvements within poor law nursing.[146] Indeed, studies of nursing within poor law institutions have been sparse, possibly because of the uncertainty surrounding the nature of those carrying out nursing duties.[147] Accounts included in general studies of nursing history have concentrated on the improvement in conditions of service and the increasing involvement of poor law nurses with acutely ill patients. Christopher Maggs' chapter in Davies' edited volume describes nurse recruitment in the late nineteenth century in one voluntary hospital and three poor law infirmaries and notes that the most significant quantitative change over the period was the rapid expansion in the number of nurses in the poor law sector.[148] Hawkins' study mainly utilises material from St George's Hospital, London and, although brief mention is made of poor law nursing, there is no acknowledgement of the use of paid, untrained nurses in workhouses. Similarly in Borsay and Hunter's collection, the poor law sector receives minimal attention, even in the section on midwifery, although the

[144] The establishing of the Nightingale School is described in detail in M. E. Baly, *Florence Nightingale and the Nursing Legacy*, London, 1986.
[145] Ibid., pp.38, 219.
[146] M. Lorentzon, 'Lower than a scullery maid', *Nursing History Review,* 7 (2003), p.7.
[147] Abel Smith, pp.10-11; S. Wildman, 'Changes in Hospital Nursing in the West Midlands 1841-1901', in J. Reinarz (ed.), *Medicine and Society in the Midlands 1750-1950,* Birmingham, 2007, p.102.
[148] C. Maggs, 'Nurse Recruitment to Four Provincial Hospitals 1881-1921', in Davies (ed.), *Rewriting English History*, p.23.

majority of births in institutions took place in the workhouse.[149] Rosemary White has provided the one dedicated account of poor law nurses, in which she points out that, despite the lack of interest by historians and the nursing profession, they nursed 75% of all hospital patients.[150] Moreover, the nature of the nursing tasks they performed and their interaction with the patients they cared for has been relatively neglected. White has been praised for doing much to rehabilitate the image of the poor law nursing service by showing that its members often achieved relatively high standards of nursing care.[151] Their status was on a par with those trained in voluntary hospitals as a substantial number of poor law probationers have been shown to have found employment in the voluntary hospital sector.[152] Another account focussing on poor law nurses is the chapter on 'Nursing in the Workhouse Infirmary' in Negrine's thesis, in which she describes how the nursing staff had to overcome the prejudices of the guardians to establish effective patient care.[153]

In contrast to the medical service, nursing was the weakest part of the care provided for patients and the lack of trained nurses was the greatest handicap for the developing poor law infirmaries.[154] Nursing duties were initially undertaken by untrained female paupers, who were noted for being inefficient and unreliable. Their duties were mainly domestic as they gave minimal personal attention and they were frequently rewarded with extra rations and alcohol, which made drunkenness not uncommon. The status of nursing in general prior to the commencement of training in the 1860s

[149] R. Dingwall, A. M. Rafferty and C. Webster, *An Introduction to the Social History of Nursing,* London, 1988, pp.157, 160; they estimate 1% of the 1.3% of births in institutions in 1890 took place in workhouses.
[150] R. White, *Social Change and Development of the Nursing Profession*, London, 1978, p.3.
[151] R. Versluysen, 'Old Wives Tales? Women Healers in English History', in Davies (ed.), *Rewriting English History,* p. 181.
[152] Lorentzon, p. 11.
[153] Negrine, 'Medicine and Poverty', pp.98-122.
[154] Flinn, p.56; Digby, *Pauper Palaces*, p.171.

was equivalent to that of domestic servants and the major source of recruits was working-class women.[155] A few guardians did employ paid nurses, but this was rare before the mid-1860s, with only 248 paid nurses in workhouses in England and Wales in 1850.[156] The first training scheme in a workhouse infirmary took place in Liverpool in 1865 and thereafter trained nurses began to be employed by guardians, although they always remained in short supply and turnover was high. Pauper nurses continued to be used until the LGB issued an order in 1897 prohibiting their use for specifically nursing duties.[157] As training became more widespread, the number of poor law nurses increased, reaching 2,490 in the separate infirmaries in 1909, where they were responsible for nursing 40,000 patients.[158] Although Abel-Smith and Digby contend that nursing staff disliked the tedium of caring for the chronic sick, White maintains that poor law nurses developed expertise in the nursing care of those with chronic illness and incurable disease and played a major part in retaining the caring role within nursing.[159]

Medical and Surgical Treatment

Notwithstanding the limited coverage in the literature on poor law nursing, even less has been documented regarding the nature of the treatments that were used in the workhouse, the impact of these on the health of patients and the medicine practised

[155] Dingwall, Rafferty and Webster, pp.10-11, 33.
[156] White, p.26.
[157] Ibid., p.87; Hodgkinson, p.569.
[158] White, p.131; Digby, *Pauper Palaces,* p.171.
[159] Abel-Smith, *The Hospitals*, p.210; Digby, *Pauper Palaces,* p.172; White, p.198.

from the point of view of the WMOs themselves.[160] Similarly, medical historiography contains little of the experiences of the poor law MOs and the 'voice' of the individual doctor has rarely been heard.[161] Because of this, local MOs will be included along with patients, older inmates and nursing staff in the focus on presenting a 'history from below' in the qualitative aspect of this study.

As the nineteenth century progressed, the understanding of the aetiology of disease changed fundamentally through the influence of scientific research and created a new form of medicine, based on the 'anatomico-clinical gaze'.[162] The seminal paper on this subject is that of N. D. Jewson, who argued that the perception of the sick-man as a 'person' altered with the shift from 'Bedside Medicine' to that of a 'case' with the onset of 'Hospital Medicine' in the early decades of the century. The former concentrated on the unique pattern of bodily events of an individual while the latter saw the sick-man as a 'collection of synchronised organs' and turned him into a passive, uncritical patient. The establishment of 'Laboratory Medicine' in mid-century removed the patient further from the consultative relationship. With the development of the cell theory, disease was viewed as originating in the cell and the sick-man as a 'cell complex'.[163] This discovery of the cellular basis of pathology along with the germ theory of disease and the development of theories of cellular immunity in the late 1880s, laid the foundation of modern medicine. The result was

[160] Hodgkinson, *Origins,* and Crowther, *Workhouse System,* each devote a chapter to this topic. They discuss it in detail in Hodgkinson, 'Poor Law Medical Officers', pp.299-338, and Crowther, 'Paupers or Patients?', pp.33-54. The subject is also covered by Flinn, 'Medical Services Under the New Poor Law'.
[161] The exceptions were Joseph Rogers, who was President of the Poor Law Medical Officers' Association and whose memoir is recorded in T. Rogers (ed.), *Joseph Rogers MD Reminiscences of a Workhouse Medical Officer*, London, 1889 and A. Sheen*, The Workhouse and its Medical Officer*, Bristol, 1890.
[162] M. Harrison, *Disease and the Modern World*, Cambridge, 2004, pp.57, 118.
[163] N. D. Jewson, 'The Disappearance of the Sick-Man from Medical Cosmology 1770-1870', *Sociology*, 10 (1976), pp.225-44.

that, by the end of the nineteenth century, the clinical management of disease and hospital treatment were a positive benefit to patient care.[164] From the 1860s, these changes and the development of clinical instruments such as the thermometer, microscope and ophthalmoscope added to the importance of the clinical examination.[165] However, therapeutics failed to progress accordingly and the medical armamentarium remained very similar to that of the eighteenth century, with a range of drugs limited to opium, hyoscine, ephedrine, atropine, ergotamine, quinine, cocaine and digoxin.[166]

The middle of the nineteenth century was also the watershed in the history of surgery, with the move into the post-anaesthetic era and the start of antiseptic wound management.[167] Despite the fact that anaesthetics were used in hospitals from the 1860s, the LGB did not approve their use in the treatment of inmates until the 1890s and in many unions pauper patients underwent operations without anaesthesia.[168] Surgical procedures with a mortality rate of around 25% or less were limited to amputation, hernia repair, removal of tumours, lithotomy and the deligation of arteries.[169] However, surgery offered the possibility of cure, whereas medical treatment remained either symptomatic or palliative in nature. The main curative methods were seen as good hygiene, adequate ventilation and sanitary reform.[170] They were more likely to be adopted in workhouse infirmaries, as new treatments

[164] W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, Cambridge, 1994, pp.100, 130, 160, 226; Abel-Smith, *The Hospitals*, pp.1-2; K. D. Keele 'Clinical Medicine in the 1860s', in F. N. L. Poynter (ed.), *Medicine and Science in the 1860s*, London, 1968, p.57.
[165] Keele, pp.1, 4.
[166] M. Weatherall, 'Drug Therapies,' in W. F. Bynum and R. Porter (eds), *Companion Encyclopaedia of the History of Medicine*, London, 1993, p.920.
[167] G. Lawrence, 'Surgery (traditional)', in Bynum and Porter (eds), p.982; U. Tröhler, 'Surgery (modern)', in Bynum and Porter (eds), p.984.
[168] Price, p.233; Brand, 'The Parish Doctor', p.120.
[169] Woodward, pp.l74, 165.
[170] For a discussion of the role of ventilation in medical treatment, see Pickstone, pp.110-12.

were introduced into poor law practice only some time after their use in the large London hospitals. In addition, the assumption that therapeutic treatment was ineffective, and so a waste of money, was prevalent.[171] This study will demonstrate whether such a viewpoint operated in Birmingham and Wolverhampton workhouses.

Summary of Thesis

While this study will analyse a variety of aspects of the institutional poor law medical service, it will attempt to bring to the fore the experiences of sick paupers and their medical attendants. The next chapter will consider those inmates who required medical treatment, what proportion they constituted of the total inmate population, the nature of their illnesses, and the medical services provided for them. It has been generally accepted that the workhouse catered almost exclusively for patients with chronic diseases, but this study will challenge that assumption by showing that a significant proportion were admitted with acute illness in the early nineteenth century and their number increased as the century progressed. However, for those inmates suffering from chronic disease, the chapter will reveal the diverse range of diseases affecting them and, uniquely, the nature and extent of their disabilities. It will demonstrate that for most of the period studied they received good quality care, ensured by a sympathetic approach from guardians. Birmingham and Wolverhampton guardians differed in how they managed arrangements for their welfare, both over time and within the two workhouses. This depiction contradicts Anne Borsay's Whiggish interpretation of the history of disability as one underpinned by the

[171] Brand, 'The Parish Doctor', p.110; Kidd, p.41.

portrayal of those with impairments being pushed to the physical margins of their community and of gradual progress toward increasing social participation.[172] Borsay argues that the exclusion of disabled people from the full rights of citizenship was not challenged until the mid-twentieth century and Victorian society practised the 'ultimate form of exclusion' by depositing disabled people into 'carceral settings', such as workhouses.[173] The finding in this study that disability based on impairment was constructed differently in two workhouses located in geographical proximity challenges Borsay's simpler model of exclusion. Guardians considered they were providing the most appropriate care available at the time for infirm paupers, though Borsay condemns this attitude as 'benevolent paternalism'.[174] However, within the context of services for the care of dependent paupers in the nineteenth century, their residence in workhouses and their infirmaries provided them with a degree of care that would not have been otherwise available. Furthermore, at that time, only a minority of citizens had the right of full social participation, which was denied to paupers of all types, and the exclusion of disabled inmates has to be seen within the context of varying degrees of exclusion of many individuals and groups within Victorian society.

One aspect of acute care, namely fevers and infectious disease takes up chapter three, which shows the considerable part the poor law authorities played in providing facilities for such patients and in containing the spread of infection within the community. In Birmingham, this extended to a jointly managed isolation hospital, in contrast to the more usual strained relationships between guardians and local

[172] A. Borsay, *Disability and Social Policy in Britain since 1750: A History of Exclusion*, Basingstoke, 2005.
[173] Ibid, pp.197-98.
[174] Ibid.,p.21.

authorities over the provision of isolation facilities.[175] The extent of this medical role beyond the workhouse's poor law function has not previously been acknowledged in the secondary literature. Although it was unusual for children to be admitted to hospital when unwell, the workhouses in Birmingham and Wolverhampton did regularly contain children with infectious disease prior to the instigation of isolation policies. The arrangements for the care of smallpox patients have not been recorded in as much detail as this study presents, demonstrating how significant they were in containing the spread of infection within the community, in addition to providing care to individual sufferers. The chapter also contains one of the few detailed accounts of the implementation within the workhouse of the same methods of treatment for patients with tuberculosis as employed in sanatoria.

The MOs responsible for looking after sick inmates form the subject of the following chapter. Issues covered include their working conditions and the extent to which their heavy workload affected the level of direct patient care they practised. Despite the constraints imposed by guardians, some managed to provide good quality and innovative care. There is no doubt that the practice of conscientious MOs benefited patients even when staffing levels were low, challenging the assertion that an inadequate number of doctors invariably resulted in low standards of care. By detailing the day-to-day work of MOs, this chapter reveals what it was like to practice medicine in the workhouse, an aspect that has not been the subject of historical study. It explains why they found it difficult to avoid conflict with guardians who wished to control costs. The context in which charges of medical negligence were made is explored, revealing that the lack of good communication between MOs and guardians

[175] S. Sheard, 'Reluctant Providers? The politics and ideology of municipal hospital finance 1870-1914', in M. Gorsky and S. Sheard (eds), *Financing Medicine: The British experience since 1750*, London, 2006, p.117.

was a critical factor. The treatment of patients is taken up in chapter 5, which demonstrates that MOs managed to prescribe the full range of treatments that were in current use in the nineteenth and early twentieth centuries and contradicts the current viewpoint that inmates were denied medical treatment. Despite guardians paying for the cost of drugs in both Birmingham and Wolverhampton, they made very few attempts to control costs or interfere with the treatments prescribed, again contrary to the prevailing opinion on medical treatment in workhouses. The one exception was their attempts to limit the use of alcohol by MOs, but these met with limited success. In some instances, MOs instigated recently introduced remedies, both pharmaceutical and surgical, and provided the same standard of treatment as they did in voluntary hospitals.

One aspect of treatment, namely giving pills and potions to patients, was the duty of the nurses, who are described in chapter 6. It gives the first detailed account of the reality of poor law nursing, revealing that their reputation of total incompetence in the early days of the NPL is demonstrably unjust. Their standards of conduct were those of the working-class in general in the nineteenth century. However, the proficiency with which they carried out their duties improved as training was introduced and nursing developed as a profession, but the high turnover rate and considerable proportion that failed to complete training were common to workhouse infirmaries and voluntary hospitals. Working conditions and salaries for nursing staff were similar in both types of institution so that nurses moved between the two. As the nineteenth century progressed, the standards of nursing care in poor law infirmaries became not dissimilar to that in voluntary hospitals. Poor law nurses are usually portrayed in the secondary literature as less efficient, more intoxicated, less well paid,

provided with less satisfactory accommodation and having longer hours of work than those in voluntary hospitals.[176] The model of poor law nursing in Birmingham and Wolverhampton workhouses contradicts this paradigm of inferior quality and quantity. Similarly, poor law infirmaries are usually depicted as providing nursing staff with less experience of acute medical care and surgery, but the large number of patients admitted to Birmingham and Wolverhampton infirmaries with infectious disease counteracts the former claim and the surgical operations listed in chapter 5 modifies the latter. They did provide greater exposure to patients with chronic conditions than voluntary hospitals, but this form of nursing is usually, but incorrectly, dismissed as requiring a lesser degree of skill.

The concluding chapter analyses the overall standards of care provided for sick inmates in Birmingham and Wolverhampton workhouses. It demonstrates that care is multi-factorial and its quality cannot be judged solely on the adequacy of medical staffing, as advocated by Price.[177] By demonstrating the positive side of NPL medical care and showing that inmates did, for the most part, receive humane care, workhouse medicine is seen as more complex than previously appreciated and as more important in the lives of sick paupers in the nineteenth and early twentieth centuries than is generally acknowledged. Thus, it challenges the accepted viewpoint that the importance of workhouse medicine was merely as a locus for the development of state medical facilities with steady progression to the founding of the National Health Service in 1948.

[176] C. Helmstadter, 'Building a New Nursing Service: Respectability and Efficiency in Victorian England', *Albion: A Quarterly Journal Concerned with British Studies*, 35 (2003), p.593; White, pp.82-84; Hawkins, p.11; Baly, p.96; Lorenzton, pp.5-7.
[177] Price, p.237.

CHAPTER 2

FROM ACUTE ILLNESS TO CHRONIC DISABILITY

'the sick and infirm… are our charge.[1]

Under the Old Poor Law, relief could be provided for medical assistance and treatment, including admission to voluntary hospitals. Workhouses provided sick wards for inmates who became ill during their stay in the institution. It was never envisaged that acute illness would be a reason for admission, but ill health turned out to be a major cause of destitution, giving rise to the need for relief under the poor law system.[2] Edwin Chadwick, Secretary to the Board of Poor Law Commissioners (hereafter PLCs), recognised that disease could be 'caused by destitution' and that greater longevity was associated with 'expensive modes of living' and considered the remedy to be sanitary improvement.[3] However, this was not until four years after the Poor Law Amendment Act (1834), which had concentrated on the problem of able-bodied pauperism and neglected to consider provision for sick paupers. John Pickstone has suggested that this concentration on able-bodied paupers helped to disguise the extent to which workhouses catered for the sick.[4] The PLCs enabled

[1] Wolverhampton Archives and Local Studies (hereafter WALS), *Wolverhampton Chronicle* (hereafter *WC*), 2 December 1846.
[2] The main studies of the poor law medical services are: E. G. Thomas, 'The Old Poor Law and Medicine', *Medical History*, 24 (1980), pp.1-19; R. Hodgkinson, *The Origins of the National Health Service: the Medical Services of the New Poor Law 1834-71*, London, 1967; M. W. Flinn, 'Medical Services under the New Poor Law' in Fraser (ed.) *The New Poor Law in the Nineteenth Century*, London, 1976; J. V. Pickstone, *Medicine and Industrial Society*, Manchester, 1985; H. Marland, *Medicine and Society in Wakefield and Huddersfield 1780-1870*, Cambridge, 1987; J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse*, Rochester, 2013; A. Gestrich, E. Hurren and S. King (eds), *Poverty and Sickness in Modern Europe*, London, 2012.
[3] British Parliamentary Papers (hereafter BPP), 1842 (006), pp.xvii-xviii.
[4] Pickstone, p.35.

guardians to provide whatever facilities they deemed necessary for 'persons labouring under any disease of body or mind' outwith the formal classification system.[5] Thus, the central authority did not define a definitive medical policy in the early days of the New Poor Law (hereafter NPL).[6] The expansion of medical relief from the late 1830s was a spontaneous development and influenced by administrative orders of the Commissioners rather than by the central authority. As Michael Flinn has put it, the NPL medical service was an 'accident of history which only the most pressing social need could have engineered'.[7]

By the mid-nineteenth century, nearly three-quarters of the cases of pauperism in England and Wales involved sickness.[8] The proportion of sick inmates rose from 10% in 1843 to between 34% and 48% in the mid to late 1860s, with the higher figure in London and the lower in provincial workhouses, and remained at this level into the early part of the twentieth century.[9] Illness and injury accounted for a substantial proportion of admissions to workhouses, for instance 62% of adult males and almost 44% of adult females admitted to Medway Union workhouse between 1876 and 1881.[10] Workhouses now began to adopt the role of hospitals and, by 1870, those in large towns had been transformed into 'infirmaries for the sick', widely regarded as the first public hospitals.[11] By 1891, the public sector provided about 83,000 beds, compared with only 43,000 by voluntary hospitals.[12] The increase in sick inmates

[5] BPP, 1844 (45), p.1.
[6] A. Digby, *The Poor Law in Nineteenth-century England and Wales*, London, 1982.
[7] Flinn, p.49.
[8] A. Digby, *Pauper Palaces*, London, 1978, p.166.
[9] Hodgkinson, pp.147, 465-67; J. Lane, *A Social History of Medicine*, London, 2001, p.64; M. A. Crowther, *Workhouse System*, London, 1981, p.89.
[10] D. G. Jackson, 'The Medway Union Workhouse, 1876-1881: A study based on the admission and discharge registers and the census enumerators' books', *Local Population Studies*, 75 (2005), p.19.
[11] D. Ashforth, 'The Urban Poor Law', in Fraser (ed.), *The New Poor Law in the Nineteenth Century*, London, 1976, p.148; Hodgkinson, p.451.
[12] B. Abel-Smith, *The Hospitals*, London, 1964, p.200.

resulted from the recognition of the benefits of institutional medical care for those who could not be cared for at home, the poor state of health of many of the paupers admitted and the growing popularity of hospitals among the poor. Also, the Poor Law Board (hereafter PLB) officially reversed the policy of less-eligibility in relation to the sick in the late 1860s and its president, Gathorne Hardy, stated that the deterrent principle was no longer appropriate. The Medical Relief (Disqualification) Act of 1885 removed disfranchisement from those receiving medical relief. However, many provincial unions were slow to implement the change and in Birmingham the sick were still subjected to the workhouse test in 1888.[13]

Another major factor in the development of poor law institutional medical care for those who could not afford private treatment was the strict exclusion policies of voluntary hospitals, rejecting those with chronic or terminal disease as well as older patients.[14] For instance, Birmingham General Hospital from its foundation refused admission to patients suspected to have itch and were reluctant to admit patients with chronic leg ulcers, as they were likely to have longer lengths of stay in hospital.[15] Furthermore, when patients who had been admitted to voluntary hospitals were deemed 'incurable', they were not allowed to remain. This happened in May 1884 to Ann Hackett, who was transferred to Birmingham workhouse from the Queen's Hospital because she was 'crippled with rheumatoid arthritis and suffered spinal caries'. According to Cornelius Suckling, who was visiting physician at both institutions, her bedsores had been in a healthy condition and nearly healed at the time

[13] S. Webb and B. Webb, *English Poor Law History Part II: Vol. I*, London, 1929, pp.319-20; Flinn, p.65; Hodgkinson, p.542.
[14] Crowther, pp.167, 180-81; Pickstone, p.223.
[15] Quoted in J. Woodward, *To Do the Sick No Harm*, London, 1974, p.47.

of transfer.[16] Claudia Edwards has demonstrated that elderly individuals were over-represented among admissions to Shoreditch poor law Infirmary, compared with their proportion in the local population, whereas the reverse was true at Bristol Royal Infirmary, a voluntary hospital.[17] As a result, 80 per cent of hospital beds for physical illness in 1861 were in poor law institutions, but, perversely, historians' interests have been focussed more on the voluntary hospital sector.[18] This disproportionate neglect may have arisen because of the difficulty in identifying medical details within poor law records, particularly relating to sick inmates, who were not identified as a separate group in official statistics until after 1913.[19]

The poor law records available vary over the study period considerably in the amount of information they contain related to sick inmates. For instance, in the early years of the NPL, detailed statistics are recorded for patients treated in the Birmingham infirmary, but, paradoxically, as both Birmingham and Wolverhampton infirmaries developed a more acute medical role, less detail appears in the guardians' minutes regarding medical care.[20] Although a large proportion of patients in workhouses suffered from chronic illnesses, identification of this group is difficult. However, Birmingham provided dedicated wards for inmates with disability, labelled 'bedridden wards', allowing the more disabled section of the 'non-able-bodied' class to be more visible. This chapter considers the types of patients that were admitted with physical illness, with the exception of communicable diseases, which are covered in the next

[16] Birmingham Central Library (hereafter BCL), Infirmary Sub Committee (hereafter ISC), GP/B/2/4/1/2, 16 May 1884.
[17] C. Edwards, 'Age-based Rationing in nineteenth-century England', *Community and Change*, 14, 2 (1999), pp.227-65, 240-41.
[18] R. Pinker, *English Hospital Statistics, 1861-1938*, London, 1966, pp.61-62; B. Harris, *The Origins of the British Welfare State in England and Wales, 1800-1945*, Basingstoke, 2004, pp.98-99.
[19] K. Williams, *From Pauperism to Poverty,* London, 1981, p.203.
[20] The nature of medical treatment carried out in the infirmaries is dealt with in Chapter 5.

chapter. It considers whether the provision for both the acutely ill and the chronically sick in the workhouses in Birmingham and Wolverhampton was different in the two towns and how it compared with the country as a whole. As the number of admissions increased as the century progressed, how did the guardians meet this increasing need for medical care and did the additional infirmary beds merely reflect much longer lengths of stay by patients with chronic illness? Jeremy Boulton, Romola Davenport and Leonard Schwarz have suggested the predominant function of eighteenth- and early nineteenth-century workhouses was the care of those admitted in the end stage of their lives, as the majority of deaths occurred shortly after admission.[21] To what extent did the workhouse perform other medical functions, such as active medical treatment for those with short-term acute disease? What was the nature and intensity of the illnesses suffered by workhouse patients and how well did the care provided compare with the general standards of medical care at the time? What were the medical conditions and levels of dependency of inmates with physical disability in two workhouse infirmaries in the West Midlands? As the infirmaries developed a greater role in treating acute illness, what was the impact on sick inmates who remained in the residual portion of the workhouse? Before addressing these issues, it is necessary to analyse the context in which the two workhouses were located.

[21] J. Boulton, R. Davenport and L. Schwarz, 'Mortality, Medicine, and the Workhouse in Georgian London, 1725-1824', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse*, Rochester, pp.58-60.

The Poor Law in Birmingham and Wolverhampton

This section analyses the provision for the indoor poor in the two towns and the context in which the workhouses provided medical care. It explores the size of the workhouses, local voluntary hospital provision, the nature of the towns and their economic circumstances. A local act of parliament in 1783 established Birmingham Parish as a Poor Law Incorporation and, in 1831, a new local act enabled ratepayers to elect 108 guardians of the poor.[22] The first workhouse, originally said to resemble 'a gentleman's house', was built at a cost of £1,173 in 1733, at a time when the population of Birmingham was just over 20,000 (Appendix F).[23] Minutes of the board of guardians reveal 369 inmates in May 1785 and 442 at Easter 1812.[24] At the end of the eighteenth century, 300 children were residing in placements throughout Warwickshire because of lack of accommodation in the workhouse.[25] An Asylum for the Infant Poor was erected in Summer Lane in 1797 to bring them under one roof within Birmingham. The number of inmates in the workhouse itself did not surpass 500 until after 1847. The workhouse was extended twice later in the century, but continued to prove inadequate for the increasing number of the poor requiring indoor relief. Although a larger building was proposed in the early 1780s, it did not get built for 60 years.[26] When the new Birmingham workhouse opened in 1852, it had accommodation for 1,610, including 17 officers, 80 tramps and 310 beds in a

[22] W. Hutton, *An History of Birmingham,* 6th edition, Birmingham 1835, p.375.
[23] Hutton, p.216. The first and second editions of Hutton's *History* record the workhouse as being the home of 400 paupers, whereas later editions state 600 paupers. In light of the number of inmates recorded in the minutes of the board of guardians in the 1780s, the lower figure appears the more appropriate.
[24] BCL, Birmingham Board of Guardians' Minute Book (hereafter BBG), GP/B/2/1/1, 30 May 1785; GP/B/2/1/2, 2 March 1813.
[25] BCL, BBG, GP/B/2/1/1, 30 March 1796.
[26] J. Reinarz and A. Ritch, 'Exploring Medical Care in the Nineteenth-century Provincial Workhouse: a view from Birmingham', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse,* p.143.

detached infirmary (Appendix G).[27] Built in the corridor style on an extensive site, its ventilation system attracted particular attention at the time.[28] Its 1,926 inmates made it the second largest workhouse in a survey of 48 provincial workhouses in the mid-1860s, compared with 3,194 in Liverpool, 1,475 in Portsea Island and a median value of 215 inmates for all 42 workhouses (Appendix H).[29] In 1870, it ranked seventh among the one per cent of English workhouses with more than 2,000 inmates, when 93% had less than 500 inmates.[30]

Birmingham Parish was completely urban in nature, smaller geographically than the Borough of Birmingham and its population was 75% of that of the borough in 1851. Its size remained unchanged as the borough expanded by the inclusion of neighbouring areas, receiving city status in 1889. The population of the parish in 1901 showed an increase of 30% on 133,215 persons recorded at the 1851 census, while the borough increase over the same period was much larger at 123% from a base of 233,841.[31] In the 1890s, the parish was the second most densely populated provincial poor law authority, with 82 persons per acre, compared with Manchester's 88 persons.[32] After the NPL, Birmingham Parish continued to function under the local act, which restricted the influence of the Poor Law Commissioners (hereafter PLCs), although they had gained greater control over the guardians by the 1850s.[33] However, poor law records always referred to the Birmingham authority as a Parish

[27] J. A. Langford, *Modern Birmingham and its Institutions*, Birmingham, 1871, pp.381-82.
[28] Hodgkinson, pp.530-31.
[29] BPP, 1867-68 (4), pp.26-157.
[30] BPP, 1870 (468 - I), pp.4-25.
[31] P. A. Tolley, 'The Birmingham, Aston and Kings Norton Boards of Guardians, and the Politics and Administration of the Poor Law, circa 1836-1912' (unpublished PhD thesis, De Montfort University, 1994), p.396.
[32] C. Booth, *The Aged Poor in England and Wales*, London, 1894, p. 96
[33] Tolley, pp.322-23; the issue of the relative independence of Local Act Unions is discussed by Driver, pp.42-57.

rather than a Union, until it amalgamated with the neighbouring unions of Aston and King's Norton in 1912 to form a greater Birmingham Union.

Birmingham Corporation was not constituted until 1838, but by 1890, it was described as the 'Best governed city in the world'.[34] A report into large towns in 1844 referred to Birmingham as 'one of the most healthy', a claim supported by the mortality statistics at that time.[35] However, the death rate increased relative to other large towns in the 1870s, prior to the reforms carried out by Joseph Chamberlain to improve gas and water supplies and sanitation, and rid the city centre of slum housing.[36] The rapid industrial expansion in the town in the late nineteenth century resulted in a highly diversified economy, which lessened the impact of industrial action in any one trade.[37] Manufacturing was centred on the metal or hardware industries, such as buckles, buttons, pins and jewellery, known at the time as 'toys'. The production of small metal items or trinkets led Edmund Burke, in 1777, to refer to Birmingham as 'the toy-shop of Europe'.[38] The manufacture of guns, swords and iron screws were among the other staple industries, while the production of iron and brass bedsteads in England was chiefly confined to the Birmingham neighbourhood.[39] The brass trade developed into the chief industry of the town, but the risk of pulmonary disease due to the inhalation of dust from the industrial process was so high that the

[34] R. Woods, 'Mortality and sanitary conditions in late nineteenth-century Birmingham', in R. Woods and J. Woodward (eds), *Urban Disease and Mortality in Nineteenth-century England,* London, 1984, p.177.
[35] E. Hopkins, *Birmingham, The Making of the Second City 1850-1939*, Stroud, 2001, p.94; Woods, p.177.
[36] A. Mayne, *The Imagined Slum. Newspaper representation in three cities, 1870-1914*, Leicester, 1993, p.60.
[37] J. T. Bunce, 'The Social and Economical Aspects of Birmingham' in S. Timmins (ed.), *Birmingham and the Midland Hardware District*, London, 1866, p.688.
[38] S. Timmins, 'The Industrial History of Birmingham', in Timmins (ed.), *Birmingham and the Midland Hardware District*, p.216.
[39] E. Peyton, 'Manufacture of Iron and Brass Bedsteads', in Timmins (ed.), *Birmingham and the Midland Hardware District*, p.624.

majority of workers suffered breathing difficulties by middle age.[40] The majority of manufacturing took place in workers' homes, workshops and small industrial units and the majority of workers were skilled or semi-skilled.[41] Birmingham was unique among the large centres of industry in the country in the number of small, independent manufacturers it supported, the jewellery trade being the prime example.[42] The diversity of trades offered a degree of protection from economic cycles and many workers were able to switch trades within the metal industry. During the seventeenth and eighteenth centuries, Birmingham had few commercial restrictions and gained the reputation as a town of liberal principles, in regard to both trade and politics.[43]

Wolverhampton Poor Law Union was established at a meeting organised by the PLCs in September 1836 as an amalgamation of the townships of Wolverhampton, Bilston, Willenhall and Wednesfield. The guardians elected to the board were of a similar social background to those in Birmingham, namely manufacturers, shopkeepers and merchants, with occasional clergymen and medical practitioners. The union inherited a workhouse at Wolverhampton, which had been erected in the 1700s, a smaller one at Bilston to accommodate up to 50 inmates, and one in Wood Street in Willenhall, which at that time was in a very dilapidated state.[44] In March 1838, there were 163 inmates in the first workhouse and 91 in the second. All were moved to a new workhouse erected in Bilston Road, Wolverhampton, on 7 October 1839 (Appendix

[40] W. C. Aitken, 'Brass and Brass Manufactures', in Timmins (ed.), *Birmingham and the Midland Hardware District*, p.363.
[41] Hopkins, pp.10, 17, 144; Woods, p.178; A. Briggs, *History of Birmingham, Vol. II, Borough and City, 1865-1938*, London, 1952, pp.1, 5-6.
[42] J. S. Wright, 'The Jewellery and Gilt Toy Trades', in Timmins (ed.), *Birmingham and the Midland Hardware District*, p.454.
[43] Timmins, 'The Industrial History', p.211; Aitken, p.255.
[44] www.wolverhamptonhistory.org.uk/work/the_workhouse, accessed 10 May 2011; The National Archives (hereafter TNA), MH12/11674, 2 April 1836, 27 August 1838.

I).[45] It was designed as a hexagonal building in keeping with one of the model plans published in the second Annual Report of the PLCs and could accommodate up to 450 paupers.[46] An auxiliary workhouse was opened in Wednesfield in August 1841, but closed after about 15 months.[47] Wolverhampton was incorporated as a borough council in 1848, the largest in Staffordshire, and as a county borough in 1889. The town's population in 1831 stood at 18,380, but it had doubled by 1851 and almost quadrupled by the beginning of the twentieth century.[48] By comparison, Bilston, which had been designated a market town in 1824, saw an increase of only 66% from a base of 14,492. The much smaller towns of Willenhall and Wednesfield, with populations of 5,834 and 1,837 respectively in 1831, experienced huge population increases, in the latter due to the expansion of housing in the area of Heath Town in 1866.[49] The erection of additional buildings at the workhouse could not keep pace with the increasing number of inmates towards the end of the century and a new workhouse was opened in Heath Town in September 1903 with accommodation for 1,301 paupers (Appendix J).[50] There was no voluntary hospital in Wolverhampton until the South Staffordshire General Hospital opened in 1849 with 80 beds. After 1948, the new workhouse became the major general hospital for the area and was re-named New Cross Hospital.

As in Birmingham, the towns that made up Wolverhampton Poor Law Union relied on metal manufacturing as their industrial base. All except Bilston specialised in lock

[45] WALS, *WC*, 14 March 1838; Wolverhampton Board of Guardians' Minute Book (hereafter WBG), PU/WOL/A/2, 27 September 1839.
[46] The National Archives (hereafter TNA), MH12/11674, 30 November 1837.
[47] WALS, WBG, PU/WOL/A/3, 22 July 1842; TNA, MH12/11675, 9 November 1842.
[48] G. Barnsby, *Social Conditions in the Black Country, 1800-1900*, Wolverhampton, 1980, pp.3-4; T. Cockin, *The Staffordshire Encyclopaedia*, Stoke-on-Trent, 2006, p.567.
[49] Barnsby, pp.3-4.
[50] WALS, *Wolverhampton Journal* (hereafter *WJ*), LS/L07/79, p.liv.

making, although many other small metal items, such as screws, bolts and guns were also produced. Wednesfield also specialised in vermin traps and Bilston in shoe buckles and enamelled trinkets. By way of contrast, Bilston saw the rapid growth of coal and iron mining in the first half of the nineteenth century. The best-known manufacturer of locks in Wolverhampton was Chubb, which developed a tamper-proof lock.[51] The staple trades of the town included tin-plate working and japanning, with the production of such articles as trays, coal vases and tea caddies.[52] Bicycle production began in the mid-nineteenth century and the Sunbeam Company turned to car production in addition in the 1890s.[53] The substantial diversification of trades within the metal industry, typically produced by small family firms, allowed workers to continue in employment when the popularity of particular items declined. However, not all were so fortunate; for instance, J. P. Taylor of 10 Horsely Fields in Wolverhampton had been employed in the locksmith industry for a short period in 1835, but was unable to find another situation in the trade and applied to the LGB for support in obtaining a loan to set up as a tobacco dealer.[54] In the next two decades, the Black Country towns experienced industrial unrest, with strikes by iron miners, puddlers and tinplate workers.[55] Sanitary conditions in the towns were severely criticised, due to the lack of facilities for sewage disposal. They were worst in Bilston, where Bilston Brook was the only source of water, but was also used for dumping waste.[56] The town experienced a severe outbreak of cholera in 1832 and ten years later, much of it remained undrained, with pools of green stagnant water

[51] J. C. Tildesley, 'Locks and Lock-making', in S. Timmins (ed.), *Birmingham and the Midland Hardware District*, pp.83-84.
[52] H. Loveridge, 'Wolverhampton Trades', in S. Timmins (ed.), *Birmingham and the Midland Hardware District*, pp.117, 122.
[53] Cockin, p.598.
[54] TNA, MH12/11674, 21 March 1837.
[55] C. Upton, *A History of Wolverhampton*, Chichester, 1998, pp.87-88; Cockin, p.597.
[56] Barnsby, pp.55-56.

throughout.[57] *The Lancet* described Wolverhampton in 1867 as a 'dirty town' where the roads were black with coal dust and 'soot begrimes the houses and the people'.[58] According to the historian George Barnsby, social conditions throughout the Black Country remained appalling throughout the nineteenth century.[59]

Birmingham poor law authorities played a major part in the provision of medical care within the town. By 1766, an infirmary wing had been added to the workhouse at a cost of £400.[60] Its capacity is uncertain, but only 37 adult patients were being cared for in May 1785.[61] Four years later, the accommodation for sick paupers was felt to be so inadequate that a detached building was approved and erected adjacent to the workhouse in 1793, as the 'Town Infirmary' at a cost of £1,475.[62] By August 1818, 94 patients were being treated in the infirmary, the number increasing steadily to about 233 in 1847.[63] New buildings were also erected in 1835 as the 'Lunatic Branch of the Town Infirmary'. In April that year, the new buildings accommodated 36 'idiotic cases' and patients suffering 'mental aberration', who would otherwise have been transferred to a lunatic asylum, but 25 insane women remained in their old apartments. As the workhouse's role in the treatment of mental illness became more important, the number of patients had increased to 78 by 1847.[64] This contrasts with another huge provincial urban workhouse in Manchester, which in 1841 housed 1,261 paupers with 268 in sick wards, but only ten lunatics.[65] The first voluntary hospital,

[57] BPP, 1842 (006), p.15.
[58] Anonymous, 'The Lancet Sanitary Commission for Investigating the State of the Infirmaries of Workhouses. Country Workhouse Infirmaries. No. IV. Wolverhampton Workhouse, Staffordshire', *The Lancet*, ii (1867), p.555.
[59] Barnsby, p.247.
[60] Hutton, pp.216-17.
[61] BCL, BBG, GP/B/2/1/1, 6 June 1785.
[62] BCL, BBG, GP/B/2/1/1, 23 March 1879, 3 June 1793.
[63] BCL, BBG, GP/B/2/1/2, 11 August 1818; GP/B/2/1/5, 12 October 1847.
[64] BCL, BBG, GP/B/2/1/3, 7 April 1835, 15 November 1837; GP/B/2/1/5, 20 April 1847.
[65] Pickstone, pp.86-87.

the General Hospital, opened in Birmingham in 1779 (Appendix F) and the second non-specialist one, the Queen's Hospital, in 1841, both providing care for the sick poor throughout the borough. Access to the former hospital was restricted for older residents of the parish as only six patients over the age of 60 years, out of a total of 127, were admitted in the first three months after it opened. Regarded as chronic cases, older patients would have been admitted to the workhouse infirmary.[66] By the mid-nineteenth century, it contained 240 beds and the Queens' Hospital 180.[67]

The infirmary for 310 inmates at the new workhouse in 1852 was described as 'one of the finest in the country'.[68] Medical cases were divided among a number of separate wards including those for common cases, convalescent patients, 'idiots' and epileptics. Detached buildings were similarly provided for fever, infectious and maternity cases (Appendix H).[69] In keeping with most workhouses at that time, the erection of extra accommodation was necessitated by overcrowding, as a result of Birmingham parish's population increasing by over one-fifth throughout the 1850s. Illness was also an important factor, giving rise to the need for extended facilities.[70] Cape Hill School was opened with 200 places for boys in 1864, alleviating some pressure on the institution and allowing the old school to be converted into an epileptic ward the following year. A more elaborate extension that same year added a further 340 places to the infirmary.[71] In 1867, isolation wards were augmented when a shed was converted into a smallpox ward, and new wards for 200 old women

[66] J. Reinarz, *The Birth of a Provincial Hospital: The Early Years of the General Hospital, Birmingham, 1765-1790*, Stratford-upon-Avon, 2003, p.24.
[67] G. Griffiths, *History of the Free-schools, Colleges, Hospitals and Asylums of Birmingham*, London, 1861, pp.165, 233.
[68] Hodgkinson, p.539.
[69] Langford, p.383.
[70] Pickstone, p.123.
[71] BCL, Visiting and General Purposes Committee (hereafter VGPC), GP/B/2/8/1/4, 1 January, 16 December 1864; GP/B/2/8/1/5, 10 November 1865.

opened the following year.[72] In 1868, *The Lancet* pronounced it 'one of the best managed of all provincial workhouses'.[73] The wards were not overcrowded at that time, with the exception of one ward holding 25 insane patients. However, in later years, overcrowding became so persistent that the guardians decided in 1885 to erect a new separate infirmary building adjacent to the workhouse. It opened four years later with a capacity of 1,511 beds, only 990 of which were in the new pavilion-style building, while the remainder were in some of the old infirmary wards. The new building consisted of nine three-storey blocks set on alternate sides of the main corridor, which was almost a quarter of a mile long (Appendix G).[74] The surgical wards and operating room were on the ground floor, while those for patients with chronic conditions were located on the third floor. Separate blocks were constructed to give four wards for 24 patients with infectious disease. By March the following year, the new infirmary was almost fully utilised, with 1,286 patients accommodated.[75] The development of the infirmary into an acute general hospital has been described by one of its former consultant physicians, George Hearn, although this is a traditional, progressive account written to celebrate the institution's centenary.[76]

By comparison, Wolverhampton's medical service for the poor developed after the setting up of the union. According to Barnsby, no Black Country workhouses had separate infirmaries when they were built and sick paupers were scattered throughout

[72] Ibid., GP/B/2/8/1/5, 27 July, 10 August 1866.
[73] Anonymous, 'Dr. Edward Smith's Reports on the Treatment of the Sick in Selected Provincial Workhouses', *The Lancet*, i (1868), p.166.
[74] H. Richardson, *English Hospitals*, Swindon, 1998, p.72.
[75] BCL, BBG, GP/B/2/1/59, 7 May 1890.
[76] G. Hearn, *Dudley Road Hospital, 1887-1987*, Birmingham, 1987.

the buildings.[77] Although the new union workhouse in Wolverhampton did not have a separate infirmary, there were infirmary wards and 'infectious wards' (Appendix I). In 1842, the former could hold 28 men and 25 women and the latter six of each sex, accounting for 23% of total beds.[78] Thirteen years later, the male sick wards had been enlarged to accommodate 45 patients, but those for women remained unchanged.[79] By 1867, additional sick wards had been built, so that the infirmary consisted of a series of buildings of various ages and 'degrees of fitness'.[80] When pressure for additional space occurred in the late 1880s, Wolverhampton guardians, following a visit to the cottage homes in Birmingham, decided to erect a similar provision. As a result, 240 children were moved out of the workhouse in November 1890.[81] By this time, the number of beds in the wards for the sick had increased to 273.[82] The equivalent wards in the new workhouse, erected at New Cross in Wednesfield in 1903, could accommodate 196 men and 150 women (Appendix J). Little further information is available in the literature regarding these workhouses or the evolution of the last one to become a general hospital, New Cross Hospital.[83]

Despite being similar industrial towns, there were differences in the structure of their populations that would influence poor law services. For instance, the overall pauperism rate for Wolverhampton was around double that for Birmingham from 1881 for three decades, although Wolverhampton's rate did not follow the reduction

[77] Barnsby, p.115.
[78] WALS, Master's Journal (hereafter MJ), PU/WOL/U/2, 16 April 1842.
[79] TNA, MH12/11682, 27 October 1855.
[80] Anonymous, 'The Lancet Sanitary Commission for Investigating the State of the Infirmaries of Workhouses. Country Workhouse Infirmaries. No. IV. Wolverhampton Workhouse, Staffordshire', *The Lancet*, ii (1867), pp.555-56.
[81] WALS, WBG, PU/WOL/A/22, 13 January 1888; PU/WOL/A/23, 7 November 1888, 4 November 1890.
[82] BPP, 1890-91, (365), p.11.
[83] One of the few studies available is D. E. Wood, 'The Poor Law in Wolverhampton 1870-1900' (unpublished BA dissertation, The Polytechnic: Wolverhampton, 1986).

in the national rate until 1911 (Appendix L). By contrast, Birmingham's had decreased sharply by 1891, reflecting Birmingham's stricter enforcement of the workhouse test as part of the crusade against outdoor relief. Indoor relief as a proportion of total relief showed marked differences between the two towns, being much greater in Birmingham than Wolverhampton from 1881, possibly also due to the influence of the crusade. However, James Turner, chairman of Birmingham guardians in 1907, explained that the high institutionalisation rate was due to the entirely urban nature of the parish, with an almost exclusively working-class population. The policy of the board of guardians was to provide out-relief whenever a 'respectable home' was available.[84] The degree of overcrowding, in terms of the number of persons per household, was more severe in Birmingham (30%) compared with Wolverhampton (19%).[85] This is likely to have contributed to a higher incidence of infectious disease, including tuberculosis.

Physical Disability

Institutionalisation was one of the responses to disabled people that took place throughout history. The trend toward greater institutionalisation in the nineteenth century had its basis in the medical model of disability, which regarded impairment as a personal tragedy and a sickness.[86] As a result, disabled people were seen as invalids, incapable of social participation. Bill Hughes argues that the medical model of disability, with its emphasis on the disabled body, provoked not only pity but also

[84] BPP, 1909 [Cd. 4835], p.339.
[85] Booth, pp.88, 92.
[86] D. M. Turner, 'Introduction', in D. M. Turner and K. Stagg, (eds), *Social Histories of Disability and Deformity*, London, 2006, p.6; B. Hughes, 'Disability and the Body', in C. Barnes, M. Oliver and L. Barton (eds), *Disability Studies Today*, Cambridge, 2002, pp.58-76.

fear in the non-disabled gaze, resulting in charitable paternalism on the one hand and segregation on the other.[87] He considered both types of response arose from 'the gaze that composes impairment as disorder'.[88] The predominant Victorian response to an impaired body was social exclusion and institutionalisation, under the ambit of medical jurisprudence, but an emotional response also took place with the provision of charitable institutions.[89] However, establishments for people with sensory impairments, such as blindness and deafness, and for children with physical ailments predominated, although they developed to a large extent only in the late Victorian period.[90] Less institutional care was provided for those who developed disability later in life, as this was seen as inevitable and incurable or even as divine punishment for past misdemeanours.[91] The concept of chronic illness, as a category of ill health, did not emerge until the twentieth century and its recognition as a social problem in the United Kingdom did not take place until after World War II.[92] Furthermore, disability studies, as an academic discipline, did not become established until the 1980s.[93] Prior to that time, historical assessment of disability had come from 'outsiders', such as doctors and policy makers, since historians had neglected this area of study, leaving it 'unhistorical as a discourse'.[94] However, major historical studies have not appeared until the twenty-first century. Anne Borsay's *Disability and Social Policy in Britain since 1750* explores the exclusion of disabled people from the full rights of citizenship

[87] Ibid.; B. Hughes, 'The Constitution of Impairment: modernity and the aesthetic of oppression', *Disability Society*, 14 (2002), pp.155-72.
[88] Hughes, 'Impairment', p.157.
[89] Hughes, 'Disability', pp.60-62.
[90] A. Borsay, 'History, Power and Identity', in C. Barnes, M. Oliver and L. Barton (eds), *Disability Studies Today,* pp.104-6; Hughes, 'Disability', p.62; Hughes, 'Impairment', p.157.
[91] Edwards, p.263; A. N. Bergen, 'The Blind, the Deaf and the Halt' (unpublished PhD thesis, University of Leeds, 2004), p. 371.
[92] C. Timmerman, 'Chronic Illness and Disease History', in M. Jackson (ed.), *Oxford Handbook of the History of Medicine*, Oxford, 2011, p.394; G. Weisz, *Chronic Disease in the Twentieth Century: A History*, Baltimore, 2014, p.176.
[93] Turner, 'Introduction', pp.2-3.
[94] S. Burch and I. Sutherland, 'Who's Not Yet Here? American Disability History', *Radical History Review*, 94 (2006), p.128; J. Anderson and A. Carden-Coyne, 'Enabling the Past: New Perspectives in the History of Disability', *European Review of History,* 14 (2007), p.447.

since 1750, while in *Chronic Disease in the Twentieth Century*, George Weisz discusses how the concept of chronic disease has altered in meaning throughout history and yet remained an imprecise term, even in the twentieth century.[95] The surveys of Birmingham's chronic sick hospitals in mid-century were impeded by the lack of an exact definition of 'chronic sick'. As a result, many older patients were labelled as chronic sick, although Michael Denham argues that negative attitudes to older people contributed.[96] Consequently, within the disabled population, older disabled people have suffered relative neglect and Julie Anderson and Ana Carden-Coyne assert that those who become more infirm in old age warrant 'vigorous academic attention'.[97] Although a sizeable proportion of workhouse inmates suffered from disability, their relative neglect within the historical discourse may have resulted also from the difficulty in identifying them within poor law institutions, a task made more difficult because those with identical disabilities could be allocated to different categories within the workhouse classification system.[98]

Workhouse Classification

The classifying and separating of different categories of inmates was one of the main elements of psychological deterrence and depersonalisation within the workhouse system.[99] This applied only to those who did not suffer from physical or mental illness for whom the guardians were allowed to provide whatever facilities they

[95] A. Borsay, *Disability and Social Policy in Britain since 1750: A History of Exclusion*, Basingstoke, 2005; G. Weisz, *Chronic Disease in the Twentieth Century: A History*, Baltimore, 2014.
[96] M. Denham, 'The Surveys of the Birmingham Chronic Sick Hospitals, 1948-1960s', *Social History Medicine*, 19 *(*2006), p.280.
[97] Anderson and Carden-Coyne, p.455.
[98] Bergen, pp.22, 115.
[99] Digby, 'Poor Law', p.17.

considered necessary and those who were suffering from acute medical conditions would usually be admitted to the general sick wards, while those with less-acute illnesses and age-related diseases would be allocated a variety of other departments. Following the report of the Royal Commission on the Poor Laws in 1834, the PLCs considered that a minimum of four 'classes' were essential for 'well-regulated' workhouse administration, namely 'the aged and really impotent'; able-bodied males; able-bodied females; and children.[100] However, their first annual report classified indoor paupers into seven groups, which included separating the 'aged or infirm' class into men and women, as it was considered that separation of the sexes of all classes was essential to good workhouse management.[101] The Commissioners issued general workhouse rules in 1842, altering the categories relating to older men and women to those 'infirm through age or any other cause'.[102] This later classification differed from the earlier one in excluding those older inmates who were regarded as healthy, who from that time could only be placed with the able-bodied groups, but allowed younger disabled inmates to be housed with non-able-bodied paupers. Anne Digby draws attention to the fact that the term 'able-bodied' was never clearly defined and suggests it included all those over 15 years of age and who could support themselves through employment.[103] Mary MacKinnon regards it as 'virtually meaningless', as it could include younger people who were incapacitated by short- or medium-term illnesses or accidents.[104] The non-able-bodied class consisted mostly of older and permanently disabled inmates.[105] Furthermore, guardians were permitted to subdivide classes in any way they saw fit, for instance by moral behaviour. Both central

[100] BPP, 1834 (44), p.172.
[101] BPP, 1835 (500), p.60.
[102] BPP, 1844 (45), p.2.
[103] Digby, *Pauper Palaces*, p.144.
[104] M. MacKinnon, 'The Use and Misuse of Poor Law Statistics 1857 to 1912', *Historical Methods,* 21 (1988), p.6.
[105] Ibid.

guidance and local workhouse officials were divided in their views over whether sick older inmates should be treated in the infirmary or placed in the ordinary wards of the workhouse.[106] In 1891, the able-bodied group were divided into those who were healthy and those who were temporarily disabled, resulting in an increase in the proportion of sick inmates. MacKinnon estimates that almost half of workhouse inmates were ill in the mid-nineteenth century.[107] As a result, inmates who would have been regarded as sick or disabled cannot be easily identified as distinct groups within the workhouse population and are to be found within various sections of the workhouse community.

Non-able-bodied adults admitted to Birmingham workhouse in the 1840s could be found in wards for aged and infirm men and women, in the insane, venereal, itch, lying-in or bedridden wards. They would also have been present in the various infirmary wards.[108] However, there is also one mention of a ward for partially disabled men, suggesting there may have been subdivision of categories of inmates in smaller wards within the broader classifications.[109] The insane wards were renamed epileptic wards after the new workhouse was built and there were dedicated wards for men with leg ulcers and 'consumptive cases'.[110] There was less choice in the placement of inmates initially in Wolverhampton union workhouse with wards for able-bodied men and women, old men, old women, boys, girls and the infirmary.[111] However, 25 years later, dedicated provision had been made for inmates suffering

[106] BPP, 1866 (372), p.1; 1867-68 (4), p.21.
[107] MacKinnon, p.7.
[108] BCL, BBG, GP/B/2/1/5, 14 August 1845; GP/B/2/1/6, 24 April 1849.
[109] BCL, House Committee (hereafter HC), GP/B/2/3/1/1, 9 August 1842.
[110] BPP, 1867-68 (4), pp.45-46.
[111] WALS, MJ, WOL/PU/U/2, 16 April 1842.

'bad legs', 'paralysis', itch and venereal disease.[112] Nevertheless, inmates with illness or disability could still be classified as able-bodied. This happened to a 35-year-old man in Birmingham workhouse who was suffering with difficulty in breathing and who subsequently died from cardiac failure.[113] In Wolverhampton, only a few of the able-bodied men were considered fit to do a 'fair day's work' in the mid-1860s and the situation was no different in the early years of the twentieth century.[114]

Medical Activity in Birmingham and Wolverhampton

The medical function of the workhouse remains undefined and how the medical space within it was used is lacking in evidence.[115] Birmingham guardians in 1818 gave the six visiting surgeons to the workhouse infirmary the authority to admit patients in emergency situations without an order from the guardians or relieving officers. Furthermore, patients could only be discharged with the permission of the surgeons. These powers continued after the NPL, until new regulations came into force in 1845.[116] From 1818, the guardians required the surgeons to provide a quarterly report of activity in the infirmary. Table 2.1 gives details for the years between 1834 and the time of the new regulations. Admissions varied markedly throughout the period with a small increase towards the end, but the number of patients remaining in the infirmary rose steadily. Discharges of patients 'relieved' or cured varied between

[112] BPP, 1867-68 (4), p.153.
[113] BCL, Workhouse Management Committee (hereafter WMC), GP/B/2/3/2/2, 28 February 1896.
[114] Anonymous, 'The Lancet Sanitary Commission for Investigating the State of the Infirmaries of Workhouses. Country Workhouse Infirmaries. No. IV. Wolverhampton Workhouse, Staffordshire', *The Lancet*, ii (1867), p.555; WALS, *WJ,* LS/LO7/79, p.lvi.
[115] S. King, 'Poverty, Medicine and the Workhouse in the Eighteenth and Nineteenth Centuries', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse*, Rochester, 2013, p.232.
[116] BCL, BBG, GP/B/2/1/2, 2 June 1818; TNA, MH12/13287, 28 December 1842.

41% and 48%, although it was usually just over 50% in the mid-1840s, while deaths remained between 10% and 14%. After 1840, between half and three-quarters of patients discharged were described as cured, rather than relieved. On average, there

Table 2.1: Admissions, Discharges and Deaths in Birmingham Workhouse Infirmary for Selected Periods, 1835-47[117]

Quarter of year to end of:	Admissions	Discharges: cured or relieved		Transferred, absconded	Died		Remaining at end of quarter	Patients as proportion of total inmates
March 1835	180	150	47%	3	44	14%	124	32%
June 1835	172	121	41%	10	43	15%	121	34%
September 1835	170	119	41%	3	29	10%	130	37%
December 1835	153	105	37%	4	37	13%	137	38%
March 1836	168	124	41%	2	45	15%	134	35%
June 1836	171	136	45%	5	45	15%	130	37%
September 1836	131	121	45%	1	33	13%	117	35%
December 1836	157	84	31%	0	56	20%	134	37%
March 1837	217	129	37%	0	77	22%	145	50%
June 1837	209	171	48%	0	51	14%	132	31%
September 1837	215	169	49%	0	50	14%	128	28%
December 1837	228	156	44%	0	43	12%	155	33%
March 1840	223	68	19%	22	56	15%	137	45%
June 1840	267	219	54%	14	45	11%	124	26%
September 1840	200	155	48%	10	39	12%	128	28%
December 1840	246	159	43%	16	42	11%	151	30%
March 1841	244	193	49%	13	50	13%	140	27%
June 1841	229	186	50%	15	41	11%	132	26%
September 1841	225	170	48%	12	44	12%	131	31%
December 1841	275	185	46%	9	42	10%	170	38%
March 1842	326	249	53%	9	72	15%	170	32%
June 1842	284	223	49%	16	36	8%	175	35%
September 1842	264	251	57%	11	37	8%	140	26%
December 1842	234	143	35%	16	38	9%	153	30%
March 1844	307	243	50%	11	57	12%	176	31%
June 1844	245	216	51%	11	41	10%	153	29%
September 1844	294	225	50%	23	44	10%	155	31%
December 1844	298	231	51%	19	45	10%	158	29%
June 1846	277	233	51%	8	47	10%	169	36%
September 1846	306	226	48%	1	52	11%	194	46%
December 1846	358	279	51%	9	55	10%	209	41%
March 1847	379	350	59%	20	70	12%	248	39%

Source: BCL, BBG, GP/B/2/1/3-5.

were around 18 admissions per week and about 125 patients in the infirmary each day in the late 1830s and 160 in the early 1840s. They were under the care of a house

[117] The percentages in the discharges and deaths columns are proportions discharged or died of the total of patients in the infirmary at the beginning of the quarter and the number of admissions. The majority of transfers were to an asylum.

surgeon and six visiting surgeons, who also attended sick paupers in the dispensary and at home. Sick inmates represented between 26% and 50% of all those in the workhouse, averaging around a third of the workhouse population.[118] In the 1840s, the infirmary provided a similar number of medical beds as the General Hospital, although it admitted a third fewer patients, and had more beds than the Queen's Hospital.[119] As a result, the wards in the infirmary were extremely overcrowded and described as 'offensive and disagreeable', with the floors covered with extra beds. For instance, the ward for 'women with loathsome disease' contained 17 patients, but only 14 beds.[120] When plans for the new workhouse and infirmary were being made in March 1849, there were 160 patients with physical illness, plus 95 who were insane, in the old workhouse infirmary.[121] Although the number of patients treated in the infirmary in Table 2.1 suggests a steady increase, there was a decline in the early 1850s, before numbers rose again in the middle of the decade (Table 2.2). In the new infirmary in 1855, the daily average number of patients had increased to 318, compared with the weekly average of 122 for the Queen's Hospital in 1857-58 and a daily average of 204 for the General Hospital in 1860-61.[122] However, the greater patient turnover in the voluntary hospitals ensured that they treated a greater number of new cases, as Table 2.3 shows for 1876. Nevertheless, the workhouse's contribution was significant in facilitating the hospitals' level of activity by accepting patients from them who required a longer in-patient stay.

[118] BCL, BBG, GP/B/2/1/3-5.
[119] Griffiths, pp.165, 233, 293.
[120] BCL, BBG, GP/B/2/1/5, 8 March 1847; 'loathsome' disease or disorder was a term often applied to leg ulceration: I. S. L Loudon, 'Leg ulcers in the eighteenth and early nineteenth centuries', *Journal of the Royal College of General Practitioners*, 31 (1981), p.264.
[121] BCL, BBG, GP/B/2/1/6, 2 January, 9 April 1849.
[122] BCL, BBG, GP/B/2/1/15, 28 February 1855; Griffiths, pp.173, 233-34.

A few years after Wolverhampton workhouse opened in 1839, medical admissions began to increase significantly. In March 1842, 36-year-old Thomas Haney was admitted because of a bowel disorder and, one month later, William Watts, a miner aged 28, with fever. Watts required re-admission early the following year because of

Table 2.2: Medical Relief in Birmingham Workhouse for Selected Weeks, 1851-56[123]

Week ending	Number of inmates	Number on medical relief	Proportion of patients to inmates	Deaths
25 October 1851	586	112	19%	3
6 December 1852	628	124	20%	4
3 January 1852	660	134	20%	3
3 April 1852	676	139	21%	1
3 July 1852	662	176	27%	1
2 October 1852	656	172	26%	3
25 December 1852	771	154	20%	1
2 April 1853	798	202	25%	5
9 July 1853	673	191	28%	2
1 October 1853	653	166	25%	2
7 January 1854	940	246	26%	8
1 April 1854	916	249	27%	9
1 July 1854	925	246	27%	9
7 October 1854	893	226	25%	1
16 December 1854	1087	280	26%	5
15 March 1856	1213	385	32%	6

Source: TNA, MH12/13297-99, 13300.

Table 2.3: New Cases of Disease Treated in Medical Institutions in Birmingham in 1876

Quarter ending on	General Hospital	Queen's Hospital	Children's Hospital	Workhouse	Borough Hospital
1 April 1876	4,883	3,767	3,421	1,074	-
1 July 1876	5,393	4,256	3,706	824	6
30 December 1876	5,048	4,940	3,206	3,850	33
Total	15,324	12,963	10,333	5,748	39

Source: TNA, MH12/13326, Medical Officer of Health's Report for 1876.

[123] The transfer of inmates to the new workhouse took place in March 1852.

Table 2.4: Inmates and Patients in Wolverhampton Workhouse, on Selected Days, 1842-45

Month, Year	Total inmates	Inmates in Infirmary			Proportion of patients to all inmates
		Male	Female	Total	
April 1842	354	24	23	47	13%
May 1842	316	20	18	38	12%
June 1842	372	25	20	45	12%
July 1842	415	29	26	55	13%
August 1842	442	34	24	58	13%
September 1842	446	18	21	39	9%
October 1842	337	14	20	34	10%
November 1842	395	17	16	33	8%
December 1842	419	22	12	34	8%
January 1843	485	22	9	31	6%
February 1843	482	28	17	45	9%
March 1843	487	26	25	51	10%
April 1843	469	21	33	54	12%
May 1843	455	26	26	32	7%
June 1843	453	26	26	32	7%
July 1843	512	27	25	62	12%
August 1843	480	28	30	58	12%
September 1843	492	23	33	46	9%
October 1843	456	28	34	62	14%
November 1843	492	27	35	62	13%
December 1843	462	23	34	57	12%
January 1844	454	23	34	57	13%
February 1844	483	26	38	64	13%
March 1844	462	26	38	64	14%
April 1844	436	28	38	66	15%
May 1844	415	26	36	62	15%
July 1844	383	29	28	57	15%
August 1844	368	28	26	54	15%
September 1844	376	26	26	52	14%
October 1844	398	28	29	57	14%
November 1844	431	28	32	60	14%
December 1844	401	26	30	56	14%
January 1845	410	26	32	58	14%
February 1845	444	28	32	60	14%
March 1845	434	28	32	60	14%
April 1845	377	28	32	60	16%
May 1845	346	25	30	55	16%
June 1845	338	25	28	53	16%
July 1845	327	25	28	53	16%
August 1845	314	24	23	47	15%

Source: WALS, Master's Journal, PU/WOL/U/2, 1842-45.

debility, which rendered him unable to work. Samuel Highland had been incapacitated due to a fractured leg for three months before he entered the workhouse

in October 1842.[124] Subsequent admissions over the following 18 months included Mary Sutherland, aged 40; Anne Langford, aged 35; and Mary Blunt, aged 55, all for debility; John Wittle, a miner aged 41, for 'disease of the head' from fever; Elizabeth Davies, aged 33, with dropsy; another Elizabeth Davies, aged 45, after suffering lung disease for two months; and Ann Smallwood, aged 54, with a three-week history of asthma.[125] At this time, there was on average 52 patients in the infirmary wards, although a gradual increase of 12% took place between 1842 and 1845 (Table 2.4). As a proportion of all inmates, those who were sick increased by 4% over this period, with roughly an equal number of men and women. When patients in the infectious and insane wards are included, the proportion increased markedly between 1842 and 1843, from 17% to 30%, and rose further to 37% in 1846 (Table 2.5).[126] The guardians were concerned about the rapidity of the increase in the number of sick paupers, but concluded that 'Not a remedy or a comfort ought to be withheld; the sick and the infirm, the destitute infant and the helpless aged, are our charge'.[127]

The proportion of sick inmates remained around the one-third level throughout the next three decades, similar to that of Birmingham workhouse, with 588 sick out of a total of 1,781 inmates in 1863.[128] Including those certified as insane in Wolverhampton in the early 1870s, this increased the share of all sick inmates to around half of the workhouse population.[129] Sixty-five inmates died in the workhouse in 1840, giving a mortality rate of approximately 16%, based on the average number

[124] WALS, WBG, PU/WOL/A/3, 24 March, 1 April 1842; PU/WOL/A/4, 28 October 1842, 6 January 1843.
[125] WALS, WBG, PU/WOL/A/4, 27 January, 17 February, 5 May, 16 June, 14 July, 29 September 1843, 29 March 1844.
[126] WALS, *WC*, 2 December 1846.
[127] Ibid; this quote appears in an abbreviated form in the heading of the chapter.
[128] WALS, *WC*, 14 August 1867; BCL, BBG, GP/B/2/1/30, 11 November 1863.
[129] Ibid., 20 November 1872.

of inmates in the year ending in March 1841 of 405. The majority of deaths took place in the age group 16 to 59 years (45%), with only 31% in those aged 60 years and above. For the 44 inmates for whom a cause of death was recorded, 13 were due to debility; five to tuberculosis; four adults to venereal disease, plus Maria Lee aged 5

Table 2.5: Sick and Total Number of Inmates in Wolverhampton Workhouse for the Years 1841-46, 1857-66, 1870-72, and Number of Deaths in Years 1857-66[130]

Year	All Inmates	Sick Inmates	Proportion of Sick of All Inmates	Deaths	
1841-42	1,999	336	17%		
1842-43	2,545	767	30%		
1843-44	2,114	576	27%		
1844-45	2,027	619	31%		
1845-46	2,250	823	37%		
1857-58	570	194	34%	118	21%
1858-59	529	121	23%	128	24%
1859-60	511	185	36%	146	27%
1863-64	575	215	37%	162	28%
1864-65	603	211	35%	169	28%
1865-66	620	220	35%	137	22%
1870	694	219	32%		
1871	659	219	33%		
1872	657	228	35%		

Source: WALS, *Wolverhampton Chronicle*, 2 December 1846, 14 August 1867, 20 November 1872.

weeks who caught venereal disease from her mother; three to liver disease; and only Samuel Lester from fever.[131] Wolverhampton's death rate increased to between 21% and 28% of admissions in the late 1850s and early 1860s, and was similar to that in Birmingham workhouse in the first half of the 1850s, namely between 18% and 28% in the first four months of each year (Tables 2.4, 2.6). The major cause of death in Birmingham was chronic lung disease, such as asthma and consumption. Most of the

[130] The numbers for 1841-46 are the total admitted to the workhouse in each year, ending at Michaelmas; for 1857-66 and 1870-74, they are the average for the year.
[131] TNA, MH12/11675, 2 June 1841; BPP, 1843 (144), p.9.

deaths occurred in old people, most likely because they were moving into the workhouse as they became frailer.[132] This is supported by the data for Wolverhampton in 1891, where 65% of workhouse deaths involved those of 65 years and over, but only 26% of deaths in the Borough were in that age group. Furthermore, the proportions of those dying between the ages of 25 and 59 years were similar (26% and 24% respectively).[133]

Table 2.6: Admissions of Sick Inmates and Deaths in Birmingham Workhouse for the Months of January to April Inclusive, 1850-54

Year	Admissions	Deaths	Mortality Rate
1850	346	96	28%
1851	295	55	19%
1852	337	61	18%
1853	427	100	23%
1854	700	134	19%

Source: BCL, Visiting and General Purposes Committee, GP/B/2/8/1/1, 28 April 1854.

The proportion of sick inmates increased to around 40% by the mid-1870s in both workhouses, with that in Wolverhampton declining by half in the 1890s (Table 2.7). In Birmingham, those who were ill reached as high as 60% of all inmates between 1885 and 1890. The explanation for this provided by a LGB Inspector was a significant increase in sick poor in large towns and it prompted the guardians to approve plans for a new infirmary managed separately from the workhouse.[134] The large share of sick inmates remained after the new infirmary opened in 1899, but the subsequent decrease six years later remains unexplained. One difficulty in making comparisons arises from the varying definitions used to determine sick inmates. The

[132] BCL, BBG, GP/B/2/1/12, 23 March 1853.
[133] TNA, MH12/11711, Medical Officer of Health's annual report for 1891.
[134] BCL, VGPC, GP/B/2/8/1/9, 14 August 1885.

majority of the numbers in Table 2.7 are based on inmates on the medical officer's (hereafter MO) relief books. However, in 1890 and 1896 for both workhouses and in 1885 for Birmingham, they relate to inmates in the 'wards for the sick'. Birmingham's number of sick inmates in 1896 is calculated from all those in the infirmary plus those in the workhouse who were 'temporarily disabled'.[135] A return in December 1869 gives details of the diseases suffered by sick inmates in the workhouses of England and Wales, with one diagnosis per inmate. Acute medical illnesses accounted for 32% of patients in Wolverhampton, 21% in Birmingham and 17% nationally; acute surgical conditions were less common, with only 8%; 0.4% and 6% respectively. Acute infectious disease accounted for less than 10% in both towns and the country as a whole, while old age was given the most frequent 'diagnosis', in around one fifth of patients. The most frequent causes of illness in Birmingham were bronchitis and emphysema (8%), rheumatism (7%), and paralysis (7%), all of which matched the national proportions. This is surprising as the workers in the brass trade, the major industry in Birmingham, experienced high levels of respiratory distress.[136] Epilepsy was also a common diagnosis (9%), but in Wolverhampton, it was recorded in 43% of patients. The very high number of epileptic patients (121) is at variance with other figures recorded in the guardians' minutes, although there is no record for this same year. Nevertheless, it is obvious that the large number of epileptics in the parliamentary paper is either a clerical error or an incorrect diagnosis on the part of the medical officer, since the national figure for epilepsy is only 3%. Ulcers of legs, or other sites on the body, were also more frequent in Wolverhampton at 11%, compared with 55 in Birmingham and 6% nationally.[137] Leg ulcers were also one of

[135] BCL, LGB Returns, GP/B/5/1/2, 6 June 1896.
[136] See Chapter 1 for details of the industry and its associated diseases.
[137] BPP, 1870 (468-I), pp.2-3, 18-21, 54-63, 83, 87, 112-13, 116-17, 146-47, 172-73, 176-77, 202-3, 206-7, 232-33, 236-37.

Table 2.7: Sick and Total Inmates in Birmingham, Wolverhampton and all England and Wales Workhouses, 1867-96[138]

Date	Birmingham			Wolverhampton			England and Wales		
	Total	Sick	Percentage	Total	Sick	Percentage	Total	Sick	Percentage
1 July 1867	1,692	577	34%	759	168	22%	96,079	23,083	24%
16 Dec. 1869	2,047	711	35%	805	285	35%	158,576	46,950	30%
January 1876	2,093	861	41%	712	287	40%	125,000	44,755	36%
August 1885	2,268	1,353	60%						
April 1888				1,011	423	42%			
October 1890	2,174	1,330	61%	768	213	28%	176,020	50,308	29%
June-July 1896	2,494	9,985	40%	951	185	19%	187,000	39,264	21%

Source: BPP, 1867-88 (445), pp.4, 58; 1870 (468I), pp.2-3, 19, 21; 1877 (260), pp.4, 10-11; 1890-91 (365), pp.1-18; 1892 (292), pp.4, 16; 1896 (371), pp.4, 26; 1896 (64B.I), pp.4, 30; BCL, HSC, GP/B/2/3/3/6, 22 January 1878; VGPC, GP/B/2/8/1/9, 14 August 1885; LGB Returns, GP/B/5/1/2, 6 June 1896; WALS, *Wolverhampton Chronicle,* 29 December 1875, 4 April 1888; WBG, PU/WOL/A/22, 6 April 1888; Williams, pp.159-60.

the commonest afflictions affecting patients in voluntary hospitals in the eighteenth century, for example 22% of inpatients in Birmingham General Hospital in the 1780s and 1790s and between 40% and 50% of surgical admissions in several voluntary hospitals in the early years of the nineteenth century.[139] Surprisingly, almost half of sufferers were under the age of 30 years.[140] Leg ulcers were one of the main reasons for inmates spending more than five years in workhouses in July 1861, accounting for11% of those given a specific diagnosis for 'Bodily Disease', only 3% less than for rheumatism, although there were no such patients in either Wolverhampton or Birmingham at that time.[141] However, in January 1861, Thomas Ferris applied to Birmingham guardians to have his leg amputated because of an 'enormous' leg ulcer,

[138] The data for England and Wales for 1867 excludes Metropolitan Unions, but they are included thereafter.
[139] J. Reinarz, *Health Care in Birmingham*, Woodbridge, 2009, p.18; Loudon, p.264.
[140] Loudon, p.264.
[141] BPP, 1861 (490), pp.ii, 168-69, 194-95.

which had been present for 25 years. The guardians deferred making a decision for one month, but the eventual outcome is not recorded.[142]

At the turn of the century in Wolverhampton workhouse, the proportion of those under the care of the MO, with the exclusion of 'imbeciles and epileptics', was only 23% (Table 2.8), although 3,257 patients had been attended in 1899.[143] However, in August 1903, the month before the new workhouse opened, only nine men and eight women were both able-bodied and in health out of a total of 880 adult inmates. Of these, 230 were in the infirmary undergoing medical treatment, plus '40 were imbeciles' and 50 epileptics.[144] After the move to the new workhouse, the medical workload remained much as before, a similar number to the 2,496 patients admitted to Wolverhampton and Staffordshire General Hospital in the year 1902-3.[145] In Birmingham, the proportion of those under medical care continued between 40% and 50% of inmates, although it was difficult to calculate precisely. Returns to the central authority were divided into those in the infirmary and those in the workhouse (Table 2.8). Infirmary inmates represent those with more acute illness, but those with chronic disease in the workhouse have been estimated from the 'able-bodied temporarily disabled' group. However, this would exclude non-able-bodied adults under the MO's care and they will be now considered.

[142] BCL, VGPC, GP/B/2/8/1/3, 11 January 1861.
[143] WALS, WBG, PU/WOL/A/28, 2 February, 16 March 1900.
[144] WALS, *WJ*, LS/LO7/79, p.lvi.
[145] Ibid., p.80; WALS, WBG, PU/WOL/A/32, 9 February 1906.

Table 2.8: Sick and Healthy Inmates in Birmingham and Wolverhampton Workhouses on Selected Day, 1899-1900[146]

Category of Inmate	Wolverhampton 1 January 1900				Birmingham 30 December 1899			
	Male	Female	Total	Percentage of Total Inmates	Male	Female	Total	Percentage of Total Inmates
Ordinarily able-bodied adults:								
in health	44	23	67	7%	107	164	271	10%
temporarily disabled	76	59	135	14%	456	344	807	31%
Children under 16 years of age			51	5%			189	7%
Not able-bodied adults	456	192	648	65%	757	586	1,343	52%
'Insane' persons	41	58	99	10%				
Total inmates	617	323	1,000		1320	1,094	2,603	
Inmates under care of medical officer, excluding 'insane'	136	90	226	23%				
Adults in infirmary							1,083	42%
Total in infirmary							1,171	45%
Total in infirmary and able-bodied temporarily disabled in workhouse							1,263	49%

Source: BCL, LGB Returns, GP/B/5/1/4, 30 December 1899; WALS, WBG, PU/WOL/A/28, 9 February 1900.

Chronic Disability

Inmates with more severe levels of disability formed a majority within the sick workhouse population and this section will concentrate on this important, but previously neglected, group. For instance, Edward Smith, MO to the PLB, noted that, among those in workhouse infirmaries classed as sick 'in the hospital acceptation of

[146] Age breakdown is not available for children in Wolverhampton workhouse and those under the medical officer's care exclude 'imbeciles and epileptics'. The Birmingham returns do not differentiate between health and sickness for non-able-bodied inmates in the workhouse.

the term', the majority suffered from diseases 'of a chronic character, mainly chest complaints and debility'.[147] One example was Manchester workhouse, which had become overcrowded in 1850 because of so many inmates with chronic disease that the guardians erected a new building to accommodate the able-bodied.[148] A survey of workhouses in England and Wales in 1869 confirmed this pattern as 77% of inmates on the MOs' books were assessed as having a chronic disorder.[149] Birmingham and Wolverhampton were just below the national average (71% and 68% respectively), but, it could be much higher in some workhouses; for example, 96% in Bath Union Workhouse, where Smith reported the MO's cases as 'totally unlike those at a general hospital'.[150] Among those diagnosed as having a surgical disease, chronic conditions were more common than acute illness, averaging 63% of all surgical cases in England and Wales and 50% in Birmingham.[151] This situation persisted into the next two decades, as can be seen from the description of a female surgical ward in Birmingham workhouse in 1885:

> The female surgical ward is another big ward. Here 69 beds, closely arranged side by side, hold their suffering occupants, most of them old and decrepit. It is impossible to enter these long wards and see, amongst the old and infirm, younger women suffering from some affliction requiring medical and surgical treatment…without pitying their condition.[152]

Nationally, 43% of sick inmates in the survey were aged 60 years and over and 21% of them had 'old age' recorded as the main disease, assuming that no-one under 60

[147] BPP, 1867-68 (4), p.5.
[148] Pickstone, pp.214-15.
[149] BPP, 1870 (468-I), pp.2-3, 63.
[150] Ibid., pp.2-3, 17, 21, 23; 1867-68 (4), p.35.
[151] BPP, 1870 (468-I), pp.2-3, 21, 23; Wolverhampton workhouse contained only one surgical patient, diagnosed with an acute condition.
[152] *Birmingham Daily Mail*, 5 August 1885.

years would be given that designation as a diagnosis.[153] The *Report of the Royal Commission on the Aged Poor* (1895) confirmed that the majority of older inmates in the late 1800s suffered chronic infirmity.[154] As older people form the majority within the disabled population, Anne Borsay has maintained that old age is an easily measured parameter of disability.[155] The proportion of older paupers among adult inmates in Birmingham workhouse steadily increased between 1841 and 1911, when it more than doubled, but with a more marked rise in 1871 (Tables 2.9 and 2.10).[156] Apart from a decrease of 12% in 1851, the proportion in Wolverhampton workhouse remained at the same level from 1851 until 1891, when it had increased to a similar level as Birmingham. However, age alone cannot predict precisely how many inmates were disabled. For instance, on one day in September 1903, 81% of inmates aged 60 years and over in Wolverhampton workhouse were unable to 'take care of themselves' due to physical or mental illness, in the opinion of the medical officer, compared with 42% in Birmingham and the national average of 61%. The difference between the two workhouses was due to all inmates aged 75 years and over in Wolverhampton needing care. Only 51% in Birmingham were dependent, with one-third more women unable to care for themselves than men.[157]

Few workhouses had dedicated wards for more dependent inmates; only three in London did in 1866, but only Lambeth provided them for both men and women. Smith was critical of the practice of 'congregating the bedridden together', as at

[153] Ibid., pp.2-3, 63.
[154] BPP, 1895 [C.7684], p.xxxvi.
[155] Borsay, *Disability and Social Policy*, p.8.
[156] Further detail on older inmates in Birmingham workhouse can be found in A. E. S. Ritch, '"Sick, Aged and Infirm'' Adults in the New Birmingham Workhouse, 1852–1912' (unpublished MPhil dissertation, University of Birmingham, 2010), pp.60-83.
[157] BPP, 1904 (113), pp.iii, iv, 127, 132.

Table 2.9: Birmingham Workhouse Population by Age Group, 1851-1911[158]

Year	Birth to 15 years		16-59 years		60-79 years		80 years and over		Total	Percentage of Older Inmates of:	
	Male	Female	Male	Female	Male	Female	Male	Female		Total Inmates	Adult Inmates
1841	166 22%	158 21%	125 16%	145 19%	77 10%	70 9%	11 1%	8 1%	760	22%	38%
1851	178 49%	135 21%	80 13%	107 17%	63 10%	58 9%	11 2%	5 1%	637	22%	42%
1861	244 16%	225 15%	262 18%	357 24%	260 17%	134 9%	7 0.5%	4 0.3%	1,493	27%	40%
1871	293 17%	219 12%	227 13%	307 17%	377 21%	252 16%	49 3%	37 2%	1,761	41%	57%
1881	180 8%	126 5%	457 20%	506 22%	635 27%	330 14%	68 3%	39 2%	2,341	46%	53%
1891	90 4%	73 3%	547 23%	458 19%	656 27%	447 19%	83 3%	56 2%	2,410	52%	55%
1901	87 3%	119 4%	585 22%	440 16%	747 28%	545 20%	76 3%	104 4%	2,703	54%	59%
1911	119 4%	68 3%	593 22%	413 15%	915 34%	435 16%	72 3%	78 3%	2,693	56%	60%

Source: Census Enumerator's Books, 1851-1911.

Lambeth, because of the detrimental effect on the sanitary arrangements.[159] However, he did suggest that older inmates who were incontinent of urine should be placed in separate wards, classing them as 'Offensive and Disagreeable'.[160] In his report on 48 provincial workhouses, Smith indicated that Birmingham provided 159 beds in the bedridden wards, 31% of total beds. The only other union designating wards as 'bedridden' was Cheltenham, with 18 beds, or 23% of total capacity. Bath provided 114 beds (27%) for invalids and Manchester, Bridge Street Workhouse, 15 beds for 'old helpless women' and 91 for 'helpless sick men' (a total of 13%).

[158] Numbers for 1851 include children in the Infant Poor Asylum, built to take children, as accommodation was not available in the old workhouse. They were transferred to the new workhouse in 1852.
[159] BPP, 1866 (372), pp.37, 73, 106, 153.
[160] BPP, 1867-68 (4), p.7.

Table 2.10: Wolverhampton Workhouse Population by Age Group, 1841-1911

Year	Birth to 15 years Male	Female	16-59 years Male	Female	60-79 years Male	Female	80 years and over Male	Female	Total	Percentage of Older Inmates of: Total Inmates	Adult Inmates
1841	31	35	30	31	42	24	3	4	200	37%	54%
	16%	18%	15%	16%	21%	12%	2%	2%			
1851	66	58	100	95	62	32	10	5	428	25%	36%
	20%	14%	23%	22%	14%	7%	2%	1%			
1861	86	113	107	109	120	35	14	24	608	32%	47%
	14%	19%	18%	18%	20%	6%	2%	4%			
1871	119	86	114	150	167	56	15	9	716	35%	48%
	17%	12%	16%	21%	23%	8%	2%	1%			
1881	157	126	153	160	204	83	24	18	925	36%	51%
	17%	14%	17%	17%	22%	9%	3%	2%			
1891	17	15	197	179	273	113	17	12	823	50%	51%
	2%	2%	24%	22%	33%	14%	2%	1%			
1901	34	21	199	152	349	175	43	28	1,001	59%	63%
	3%	2%	20%	15%	35%	17%	4%	3%			
1911	51	37	221	180	312	107	34	19	961	49%	54%
	5%	4%	23%	19%	32%	11%	4%	2%			

Source: Census Enumerator's Books, 1851-1911.

Dependent patients might not always be placed with sick inmates. In York Street workhouse in Nottingham in 1841, three men suffering from paraplegia or spinal and hip disease were in the sick wards, while three with paralysis and one with spinal disease, plus four women with paralysis, were in wards in the workhouse.[161] In Battle workhouse in 1873, half of the 189 inmates classed as 'infirm or disabled' were in the infirmary and the others in the main workhouse building.[162]

[161] E. C. Bosworth, 'Public Healthcare in Nottingham 1750-1911' (unpublished PhD thesis, University of Nottingham, 1998), pp.215-16.
[162] M. Railton and M. Barr, *Battle Workhouse and Hospital, 1867-2005*, Reading, 2005, p.49.

'Bedridden Wards in Birmingham Workhouse'

As Birmingham had specific wards for those with disability, designated 'bedridden wards', identification of the more disabled section of 'non-able-bodied' adults is possible. However, detailed recording of the medical condition of these inmates did not take place, but their proportion and the levels and nature of their disabilities can be determined. The first reference to these wards was in a list of appointments in April 1842, when Mary Ann Raven was appointed as nurse in No. 9 ward, the women's bedridden ward, at an annual salary of £8.[163] The following year, she was transferred to the kitchen in an exchange with Fanny Giles.[164] Dependent patients were also present in the women's infirm ward, where many were in a 'helpless and weak state' and required as much attention during the night as in the daytime.[165] The men's bedridden ward did not have a designated nurse until 1848, with the appointment of Ann Brittain at a salary of £10 *per annum*. Two years' later, Ann Edwards, who was then nurse on the women's ward, was delegated to take charge of the men's ward as well, since the nurse for that ward had left. The guardians recognised the need for the care of the bedridden, whom they considered 'very helpless creatures' requiring 'a responsible person' to assist them.[166] Thereafter, one nurse was appointed for each ward. At that time, neither the guardians nor the MOs regarded those in the bedridden wards as sick. In their recommendation in 1849 as to the maximum number of inmates the workhouse could accommodate, they included bedridden inmates among those 'in health'. They allocated 73 beds in the bedridden wards, making up 11% of total accommodation and 17% for those designated as

[163] BCL, HC, GP/B/2/3/1/1, 5 April 1842.
[164] Ibid., 16 May 1843.
[165] Ibid., 7 June 1842.
[166] BCL, BBG, GP/B/2/1/7, 2 April 1850.

healthy paupers; in addition, there were 160 beds for 'sick' inmates and 95 for 'lunatics'.[167]

Accommodation in the bedridden wards in Birmingham was insufficient in 1860, within eight years of the opening of the new workhouse, resulting in unoccupied children's dormitories being used to accommodate these patients throughout the year.[168] Overcrowding in the wards had more impact on male patients, with 36 in a ward meant to accommodate only 30.[169] The situation had deteriorated to such an extent that, in May 1865, all 83 bedridden men were scattered throughout the workhouse with none of them in the appropriate ward. By contrast, all 63 bedridden women were in their designated ward, with seven beds vacant. Together, they constituted 31% of those classified as older inmates (Table 2.11).[170] The following year, 141 (29%) of the 481 patients in the infirmary were described as bedridden.[171] The 77 men were nursed by Edward Shubotham, who also had responsibility for the male convalescent ward and the 'bad-leg and venereal ward', resulting in an additional 58 patients under his care. He was assisted by 13 paupers. Jane Smith had charge of the female bedridden department, which incorporated the 'bad-leg ward' and was assisted by four inmates.[172] The MO was satisfied with the quality of the nursing care, pointing out that only one woman in the bedridden wards was suffering from 'bed-sores' and these had been present on admission. The patient suffered from paralysis and had been provided with 'water-cushions'.[173] By the early 1870s, accommodation had been increased to 212 beds (98 for men and 114 for women),

[167] BCL, BBG, GP/B/2/1/6, 9 April 1849.
[168] BCL, VGPC, GP/B/2/8/1/3, 27 January, 2 November 1860.
[169] BCL, VGPC, GP/B/2/8/1/3, 14 June 1861.
[170] BCL, VGPC, GP/B/2/8/1/4, 22 May 1865.
[171] Ibid., GP/B/2/8/1/5, 23 March 1866; BPP, 1867-68 (4), pp.45-46.
[172] BCL, VGPC, 2/8/1/5, 23 March 1866; BPP, 1867-68 (4), pp.46, 50.
[173] BPP, 1867-68 (4), p.48.

which were only 87% occupied, so that the bedridden patients made up 17% of all those in the infirmary and 31% of older inmates.[174] The number of women (109) in the bedridden wards in 1873 showed an increase of 70% over that in 1866. An even greater increase of 100% of 'chronic, permanent and bedridden female cases' took place in Leicester workhouse between 1866 and 1872.[175] However, severely disabled

Table 2.11: Number of Patients in the Bedridden Wards in Birmingham Workhouse, 1865-1911

Year	Men	Women	Total	Comment
1865	83	63	146	31% older inmates
1866	77	64	141	29% sick inmates
1873	97	109	206	31% older inmates 17% sick inmates
1885	134	154	288	21% sick inmates
1891	60	66	126	
1911	30	103	133	

Sources: BCL, VGPC, GP/B/2/8/1/4, 22 May 1865; GP/B/2/8/1/5, 23 March 1866; HSC, GP/B/2/3/3/3, 3 June 1873; VGPC, GP/B/2/8/1/9, 14 August 1885; HSC, GP/B/2/3/3/13, 8 December 1891; WMC, BP/B/2/3/6, 16 June 1911.

patients were to be found in other departments and not included in the bedridden numbers; for instance, the Commissioner in Lunacy had noted that 13 men in the wards for epileptics and lunatics were bedfast and, on another visit, 20 inmates in the same department were confined to bed.[176]

[174] BCL, House Sub-committee (hereafter HSC), GP/B/2/3/3/3, 3 June 1873.
[175] A. Negrine, 'Medicine and Poverty: A Study of the Poor Law Medical Services of the Leicester Union 1876-1914', (unpublished PhD thesis, University of Leicester, 2008), p.127.
[176] Ibid., GP/B/2/3/3/2, 25 October 1870; LGB Letters, GP/B/1/2/1/1, 18 February 1871.

In 1885, the guardians gave consideration to the number of beds that would be required in the proposed new infirmary and to those sick inmates who would need to be transferred there from the workhouse. They suggested that the 288 patients in the bedridden wards should remain in the house, as they required mainly nursing care and were not 'classed under the head[ing] of sick'.[177] The MO disagreed, assessing half the patients as requiring acute care and 144 beds were allocated for them in the infirmary. The guardians later decided that those patients who never or only occasionally required medication should be retained within the wards in the workhouse.[178] The 288 bedridden patients constituted 21% of the 1,353 inmates in the sick wards, but after the acute cases had been transferred to the infirmary, their number within the workhouse decreased to 126 in 1891.[179] They remained at this level into the twentieth century, but with a preponderance of female patients; for instance in 1911, there were 103 women but only 30 men.[180] Until this time, there had been generally similar numbers of bedridden patients of each sex, in contrast to the much greater number of men in the 'aged' inmates' wards. The female bedridden department was divided into four wards, each with one nurse in charge, although the wards varied in size between 10 and 38 beds.[181] Three years later, similar proportions (35 men and 112 women) continued to occupy the bedridden wards, the majority of whom were older adults. However, there were also 84 men in the male chronic ward in the workhouse, plus 61 patients of unrecorded gender in the convalescent ward. Most of the patients in these two wards were 'crippled' or suffering from cardiac or respiratory disease.[182]

[177] BCL, VGPC, GP/B/2/8/1/9, 14 August 1885.
[178] BCL, BBG, GP/B/2/1/57, 19 June 1888.
[179] BCL, VGPC, GP/B/2/8/1/9, 14 August 1885; HSC, GP/B/2/3/3/13, 8 December 1891.
[180] BCL, WMC, GP/B/2/3/2/6, 16 June 1911.
[181] Ibid.
[182] BCL, Birmingham Union Board Minutes (hereafter BUB), GP/B/2/1/83, 23 September 1914.

Disabled patients were usually included in those described as infirm, making it difficult to identify the extent of their disability.[183] Although designated as 'bedridden wards', these wards were occupied by patients exhibiting varying degrees of dependence. In 1866, one third were reported as able to 'leave their beds and their rooms'.[184] No further information is available until the 1890s, when it was recorded that some of the 126 bedridden patients (60 men and 66 women) were able to do light work in the workhouse and four did knitting and sewing and one inmate in the male department was occupied in carving frames. The reasons for the 127 inmates who were too disabled to do the 'work of the house', were age in 65 men and 22 women, blindness in 16 men and 4 women, and infirmity in 6 men and 14 women.[185] The census of April that year recorded 11 men and five women as blind among the 1,184 inmates in the workhouse. Three of the men were aged in their forties or fifties and another three men and two women were over 70 years of age.[186] Blindness was a common cause of admission to the workhouse. For instance, in a study of residents of Herefordshire suffering from disability in 1851, Christine Jones found that the majority of those who were blind were receiving either indoor or outdoor relief. Ten years later, only 32% of blind adults were in work.[187] In 1873, there were nine women in the 'Blind Womens Room' in Birmingham, although only eight beds were provided.[188]

In 1907, Miss Stannier was in charge of 36 patients in one of the bedridden wards with 36 patients under her care and Miss Rigby in another with 48 patients. The

[183] Negrine, p.134.
[184] BPP, 1867-68 (4), p.45.
[185] BCL, HSC, GP/B/2/3/3/13, 8 December 1891.
[186] Census Enumerator's Books (hereafter CEB), 1891.
[187] C. Jones, 'Disability in Herefordshire, 1851-1911', *Local Population Studies*, 87 (2011), pp.34, 39.
[188] BCL, HSC, GP/B/2/3/3/4, 25 November 1873.

patients in both wards all had breakfast in bed, but some did get up for dinner. In contrast, inmates in the wards for aged men and women were able to do ward cleaning and washing-up.[189] By 1911, the levels of dependence had increased significantly as 68 of 71 women in two of the wards in the female bedridden department were described as 'actually bedridden'. In one of the wards, all of the 35 patients were bedridden except for one and were being cared for by a nurse and three inmates. Mr E. B. Wethered, Local Government Board (hereafter LGB) inspector, considered that this ward required two trained nurses.[190] One reason for the increasing dependency levels was that the guardians had agreed that patients could be transferred from the infirmary to the workhouse for convalescence.[191] However, this resulted in the chronic and convalescent wards taking patients with severe disability and the workhouse medical officer (hereafter WMO) commented in 1893 that these wards 'were practically the same as the bedridden wards'.[192] Following his appointment as Medical Superintendent in 1913, Dr Frederick Ellis devised a scheme to improve the classification in the infirmary and workhouse, based mainly on physical ability. Inmates unable to work because of infirmity were classed as 'The Infirm', but men between 60 and 66 years were allocated to this group only if 'so physically crippled to merit infirm'. 'The Bedridden' group contained those who found it necessary to be in bed part of the day or at least part of some days during the week, as well as those who were in bed continuously and with no hope of improvement or where skilled nursing was unnecessary.[193]

[189] BCL, HSC, GP/B/2/3/3/22, 9 April 1907.
[190] BCL, WMC, GP/B/2/3/2/6, 16 June 1911.
[191] BCL, BBG, GP/B/2/1/57, 19 June 1888.
[192] BCL, HSC, GP/B/2/3/3/15, 21 March 1893.
[193] BCL, BUB, GP/B/2/1/83, 23 September 1914.

The majority of inmates in the sick wards in the mid-nineteenth century suffered from chronic diseases such as consumption, bronchitis, paralysis and debility.[194] The nature of the medical condition of the inmates in the workhouse infirmary prompted the *Birmingham Daily Mail* to comment, following a visit in 1885, that 'there are comparatively few really sick. It is not so much disease as decrepitude that has to be treated here; and not so much physic as food and nursing that is required'. The article includes a description of the patients in one of the bedridden wards:

> Take for example the largest of female bed-ridden wards. It is a long apartment with 81 beds in it, 80 of which are now occupied. No measurement can give any idea of it, but imagine a room, not over lofty, with 81 beds as close as they can possible be packed to allow room to pass between them, all filled with decrepit, withered, and haggard specimens of humanity in all stages of senile helplessness. Some are lying in their beds asleep, with the clothes drawn over their faces, inert and seemingly lifeless. Some are sitting crouched up in bed poring over scraps of periodicals. One or two are creeping about the room, getting about a bit.
>
> In this ward the beds run in four rows, with a low wooden partition between the two centre rows, and here are these people herded close together, with nothing to do but to gaze at one another, to grow callous to one another's sufferings, to see one by one their fellow inmates grow stiff and cold in their beds, and speculate upon whose turn it will be next.[195]

The patients transferred from the infirmary to the convalescent wards in Birmingham workhouse in 1911 suffered mainly from paralysis, blindness, deafness and bronchitis.[196] However, specific diseases were now being recognised as a cause of dependency, rather than age *per se*, as was the case in 1852, when the WMO reported that two or three inmates were 'disabled by age and removed to the bedridden

[194] BPP, 1867-68 (4), p.5; 1870, (468-I), pp.53-54, 57.
[195] *Birmingham Daily Mail*, 20 July 1885.
[196] BCL, WMC GP/B/2/3/2/6, 28 April 1911.

wards'.[197] The failure to recognise the importance of multiple pathologies as a reason for disability in old age was due to the practice of making a single diagnosis for each patient and this was reflected in the lack of diagnostic depth on death certification in workhouses.[198] At the turn of the century, the bedridden wards in Birmingham could include younger disabled adult inmates, such as 'chronic cripples and paralytics', as the MO reported that it was no longer the age of 60 years which determined whether 'a man' was 'able-bodied or infirm', but his physical condition. The change was prompted by the issue of a LGB Order relating to the dietaries of the various classes of inmates, in which the classification of inmates according to age was superseded by one based on their physical condition.[199] This meant that older inmates with a disability, but not dependent, could reside in the wards for able-bodied or older inmates. For instance, 70-year-old Michael Hussey who had a 'wooden leg', requested to be discharged from the workhouse, as he felt sure he could obtain work.[200] This may not have been an unrealistic view, as over 60% of adult males with a disability were in work in the 1860s.[201]

In the 1890s, Ebenezer Teichelmann, resident WMO, reported that a considerable part of his time was spent treating women in the bedridden wards.[202] In 1906, Mr Herbert, LGB inspector urged the Birmingham guardians to transfer the bedridden patients to the infirmary as he felt their quality of life would be improved by the more highly skilled infirmary nurses.[203] Five years later, the Workhouse Management Committee

[197] BCL, BBG, GP/B/2/1/11, 5 June 1852.
[198] G. Mooney, 'Diagnostic Spaces: Workhouse, Hospital, and Home in mid-Victorian London', *Social Science History*, 33 (2009), pp.357-90.
[199] BCL, WMC, GP/B/2/3/2/3, 7 December 1900.
[200] BCL, WMC, GP/B/2/3/2/4, 14 April 1905.
[201] Jones, p.43.
[202] Ibid., GP/B/2/3/2/1, 11 April 1890.
[203] BCL, HSC, GP/B/2/3/3/22, 27 February 1906; see Chapter 6 for discussion on nursing staff in Birmingham infirmary.

were concerned that some of the bedridden cases required the attention of two nurses and would be better served by the nursing care provided in the infirmary.[204] Despite their concerns, the bedridden wards remained in the workhouse and were no longer considered part of the medical provision. In a national return of inmates occupying the wards for the sick in June 1896, Birmingham guardians declared 917 sick and bedridden patients in the separate infirmary, but none in the workhouse. However, there were 818 non-able-bodied adults in the workhouse at that time and some of those would have been in the bedridden wards, as they had not been transferred to the infirmary.[205] Nevertheless, it is clear they were no longer regarded as requiring medical care, an attitude that prevailed elsewhere. The WMO at Battle workhouse in the first decade of the twentieth century attributed overcrowding in the infirmary to the number of infirm inmates who needed attention, but not medical treatment or skilled nursing.[206] This viewpoint was also reflected in the decision by the Birmingham guardians to change the designation of officers employed in the workhouse wards from nurses to attendants. However, they were forced to rescind this a few months later because of the difficulty in retaining sufficient staff.[207] The bedridden wards remained in the workhouse and, from early in the twentieth century, the movement of patients was from the infirmary to the workhouse, where the chronic and convalescent wards became occupied by inmates who suffered from severe disability. At times, the infirmary was required to take bedridden patients from the

[204] BCL, WMC, GP/B/2/3/2/6, 28 April 1911.
[205] BPP, 1896 (371), p.28; BCL, LGB Returns, GP/B/5/1/2, 30 May 1896.
[206] Railton and Barr, pp.132-33.
[207] BCL, WMC, GP/B/2/3/2/1, 10 July 1891; HSC, GP/B/2/3/3/13, 8 September 1891; see chapter 6 for more detail.

workhouse when it was overcrowded, but always on the understanding they would return in due course.[208]

In Ellis' scheme for classification of the indoor poor in 1914, he considered essential for the economic administration of the infirmary that 'chronic cases' not requiring medical or nursing skill should be removed to the workhouse. He gave examples of patients with leg ulcers and 'chronic sores'. There were three male and three female wards in the infirmary for 'chronic cases', where patients could receive treatment for a 'fair length' of time, namely for several months. He estimated that up to 55 of such patients could be transferred at that time.[209] The transfer of chronically disabled patients from acute hospitals and infirmaries became standard practice nationally. According to Weisz, as hospitals became more medicalised, they frequently denied admission to 'chronics' on the grounds that there was nothing medically that could be done and beds should be reserved for those who might benefit from medical treatment.[210] Poor law infirmaries could not refuse admission to paupers and so needed to make transfer arrangements. For example, Leicester poor law infirmary at North Evington transferred patients to the local workhouse, despite the infirmary having infirm wards for patients not requiring 'sick nursing'. Bedridden patients and those suffering for paralysis were among those sent to the workhouse, where the MO described their move as inappropriate.[211] One of the reasons in defence of this practice given by the Chief Medical Officer in 1930 was that the continued presence of such patients in a hospital would lower medical and nursing standards throughout

[208] BCL, Workhouse Infirmary Management Committee (hereafter WIMC), GP/B/2/4/4/3, 18 March 1898.
[209] BCL, HC, GP/B/2/3/14/1, 16 September 1914.
[210] Weisz, p.7.
[211] Negrine, pp.217-20.

the institution.[212] This policy cemented Birmingham workhouse's role as the main provider of care for chronic illness and disability and it was no surprise that it became a specialised geriatric hospital in 1948. In that year, the Birmingham Chronic Hospital Survey reported that nearly half of the male patients and just below two-thirds of the women in the hospital were bedridden.[213] According to Weisz, poor law institutions such as Birmingham workhouse became seen 'as a dumping ground for indigent elderly and chronically ill people'.[214] The practice of removing long-stay patients from the acute hospitals gave rise to the division in British hospital medicine between a voluntary sector that dominated acute care and a public sector in which the older, 'chronic' patient was located.[215]

Dependent Patients in Wolverhampton

The ability to identify severely disabled patients in the Birmingham poor law records has aided the understanding of the establishment of chronic hospitals within the National Health Service, but it has been more difficult to determine how smaller workhouses, such as Wolverhampton, managed these patients. In Wolverhampton, the wards, as recorded in master's journal in 1842, were for able-bodied inmates or old men and old women, plus infirmary wards.[216] However, the guardians' minutes contain a reference to an 'aged infirm' women's ward and, ten years later, to male and

[212] M. J. Denham, 'The History of Geriatric Medicine and Hospital Care of the Elderly in England Between 1929 and the 1970s', (unpublished PhD thesis, 2004), pp.60-61.
[213] Denham, 'Surveys of the Birmingham Chronic Sick Hospitals', p.282.
[214] Weisz, p.181.
[215] M. Gorsky, 'Creating the Poor Law Legacy: Institutional Care for Older People Before the Welfare State', *Contemporary British History*, 29 (2012), p.442. Similarly, voluntary and municipal hospitals in the USA sought to eliminate patients with chronic disease, Weisz, pp.58-59.
[216] WALS, MJ, PU/WOL/U/2, 16 April 1842.

female infirm wards, but it is uncertain how dependent inmates in these wards were.[217] Around this time, Mr Dunn, and his children were allowed to leave the workhouse, but his wife, who was paralysed and partially disabled, remained, as she was in constant danger of falling into the fire. He was unable to earn sufficient money to pay for a nurse to take care of her at home, but he agreed a weekly payment to the guardians of 2s and 6d.[218] Bedridden patients were first mentioned by the WMO in 1863, when he transferred them out of the cottages in order to use these buildings for patients with smallpox.[219] As in Birmingham, overcrowding took place in the workhouse in 1866, when there were around 260 sick and infirm inmates (36% of the total), of whom 200 were considered by the MO to be chronic cases, unlikely ever to leave the workhouse.[220] The lack of sufficient accommodation may have been the reason for 10 'crippled or infirm' men residing in the able-bodied ward.[221] When a correspondent from *Wolverhampton Chronicle* visited the sick wards 20 years later, one man aged over 80 years of age had been an inmate for more than 40 years, while some of the 'very old' women were bedridden.[222] When Edward Smith, MO of the PLB, visited the infirmary in 1867, there was an eleven-bedded ward for 'aged and incurable' females, and two similar sized wards for paralytic males and females.[223] However, the occupants of these wards get no mention in the guardians' records.

Toward the end of the century, 83 of the 225 patients in the infirmary were described as requiring 'everything done for them' and 16 children were included in that

[217] WALS, WBG, PU/WOL/A/3, 24 March 1842; PU/WOL/A/8, 29 October 1852.
[218] Ibid., PU/WOL/A/6, 14 August 1846.
[219] WALS, *WC*, 18 November 1843.
[220] Ibid., 28 November 1866.
[221] Anonymous, 'Wolverhampton Workhouse, Staffordshire', *The Lancet*, ii (1867), p.555.
[222] Ibid., 14 July 1886.
[223] BPP, 1869-70 (14), p.153.

number.[224] One of the children may have been Mary Ann Wilkes, an illegitimate child of 13 years, suffering from 'Spinal Caries' and hip joint disease. At the MO's instigation, the guardians agreed to her transfer to the Royal Alexandria Children's Hospital in Rhyl and pay 8s weekly toward her keep.[225] On the first of January 1900, 725 (56%) inmates were over 65 years of age, with 275 (38%) of those over 70 years. Of this latter group, 80 (29%) were in the infirm wards or in the infirmary; of the 450 inmates aged between 65 and 70 years, 130 (29%) were also in these wards. There was a greater preponderance of men, namely 57% of those aged above 60 years and 64% of over 70-year-olds.[226] In the new workhouse in 1903, wards for partially able-bodied and older adults could accommodate 440 inmates (66% of the accommodation for non-sick inmates). The infirmary had 280 beds for surgical, medical and chronic cases out of a total of 502.[227] However, the 'mental and epileptic wards' contained sick and bedridden patients, who were to receive similar diets the equivalent to patients in the infirmary.[228] In 1912, Mr L. W. Riley successfully applied for the admission of his 'paralysed wife' to the infirmary, contributing 10s and 6d to her keep.[229] The guardians obviously considered her admission appropriate, at a time when such patients were thought inappropriate in Birmingham infirmary. There is no further information on patients with chronic disease in the new workhouse and Wolverhampton workhouse appears typical of most poor law institutions, by not facilitating identification of this particular group of inmates. With no separation between infirmary and workhouse, the institution developed into a single general hospital.

[224] WALS, WBG, PU/WOL/A/25, 25 January 1895.
[225] TNA, MH12/11715, 8 July 1898; the most likely diagnosis in this case was tuberculosis.
[226] Ibid., WALS, WBG, PU/WOL/A/28, 9 February 1900.
[227] WALS, *WJ*, LS/L07/79, p.liv.
[228] WALS, Special Committees, PU/WOL/P/1, 2 April 1906.
[229] WALS, HC, PU/WOL/E/4, 25 April 1912.

Acute Medical Care

Where a geographically separate infirmary was established, two distinct institutions evolved in the early twentieth century. Brian Abel-Smith has made the point that in urban areas, patients were divided into those with acute illness, who went to the infirmary, and the chronic sick, who went to the workhouse.[230] By the early twentieth century, Birmingham infirmary had adopted the role of a general hospital, becoming the institution for acute medical care. It began accepting patients involved in accidents and this work increased during the first decade of the twentieth century (Table 2.12).[231] Of the 480 cases admitted in 1910, 295 were discharged on the same day and 184 detained as inpatients. The accidents had occurred at home, at work or in the street in 359 cases, while the police had brought in the remaining patients.[232] In 1907, Henry Manton, a Birmingham guardian, described it as a 'casualty hospital', as it could not refuse to admit those who had suffered accidents, given its position in the centre of the city and surrounded by factories.[233] Three quarters of admissions were admitted directly to the infirmary, rather than via the workhouse, and many were not paupers. Manton cited the example of a lady who sustained an accident while riding her bicycle and was admitted for three weeks. Her husband made a voluntary financial contribution for her care.[234] Although many patients were admitted with acute conditions, such as pneumonia, typhoid and rheumatic heart disease, Otto Kauffman, visiting physician, admitted that the majority of patients had chronic

[230] Abel-Smith, p.209.
[231] BCL, Infirmary Management Committee (hereafter IMC), GP/B/2/4/4/5, 8 April 1907; Hearn, p.24.
[232] BCL, IMC, GP/B/2/4/4/6, 9 January 1911.
[233] BPP, 1909 [Cd. 4835], p.342.
[234] Ibid.

conditions, particularly tuberculosis.[235] The medical superintendent's scheme to transfer patients with long-term conditions to the workhouse after an initial stay in the infirmary was designed to emphasise the infirmary's role as an acute-care facility.[236] By giving preference to acute illness and excluding older and disabled patients, he attempted to emulate the policies of the voluntary hospitals.

Table 2.12: Number of 'Casualty Cases' Admitted to Birmingham Infirmary, 1904-1910

Year	1904	1905	1906	1907	1908	1909	1910
Number	78	135	177	248	271	364	480

Source: BCL, Infirmary Management Committee, GP/B/2/4/4/5, 24 January1910; GP/B/2/4/4/6, 9 January 1911.

However, those involved in accidents had been brought directly to the workhouse before the early twentieth century. For instance, among inmates involved in accidents admitted to Leicester workhouse in 1873 were one with a fracture of the thigh, one with fractured ribs, four with fractures of the arm.[237] In the 1840s, Thomas Wilshaw was brought to Wolverhampton workhouse having fallen from the shafts of a van that had then passed over his body. Although the MO was in immediate attendance, he died in less than an hour after arrival.[238] A week later, another man was brought after being run over by a vehicle and received attention from the MO.[239] A few years earlier, Samuel Highland had been admitted after fracturing his leg.[240] George Roberts was admitted in 1855 after having cut his throat, which was sutured and

[235] Ibid., p.773; see chapter 3 for further discussion of tuberculosis, which was a common condition in workhouse infirmaries.
[236] Hearn, p.35.
[237] A. Negrine, 'Practitioners and Paupers', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse*, Rochester, 2013, pp.202-3.
[238] WALS, MJ, PU/WOL/U/2, 16 August 1845.
[239] Ibid.
[240] WALS, WBG, PU/WOL/A/4, 14 October 1842.

bandaged by the MO.[241] Paupers also suffered injuries, both accidental and deliberate, while resident in the workhouse. In Wolverhampton workhouse, Thomas James Lovatt was scalded while taking a bath and died two days later from 'shock', while Martha Forrester, aged 84 years, fell on the old women's ward, fracturing her thigh.[242] A similar occurrence happened in Birmingham workhouse to an old man, Edward Heap, who was pushed over and dislocated his hip, while 84-year-old, James Potter, was injured by a tile falling from the roof of the aged men's ward.[243] In 1886, 68-year old William Peters managed to obtain a knife, with which he deliberately cut his abdomen.[244] This is one example of patients admitted with mental illness being prone to attempted suicide and self harm.

There is scant information on the impact of medical treatment in workhouses on the lives of nineteenth-century paupers.[245] In 1895, Wolverhampton guardians received a letter from a resident at Blakenhall expressing his 'sincere thanks' for their kindness in supporting him and his family, presumably with intermittent outdoor relief, during the five years in which he had been unable to work. He had kept at work as much as he could, but had recently been admitted to the infirmary so ill that he 'thought to die'. However, he was discharged 'completely cured' after a few weeks and has been able to resume work to support his family.[246] Eighteen years later, the guardians received letters of appreciation for the kindness shown by staff to two patients, one of whom had died.[247] An expression of his appreciation was received by Birmingham guardians in 1884 from F. Broderson for the 'extreme kindness' with which he was

[241] TNA, MH12/11682, 2 February 1855.
[242] WALS, WBG, PU/WOL/A/25, 13 March 1896; HC, PU/WOL/E/1, 13 December 1902.
[243] BCL, WMC, GP/B/2/3/2/1, 15 June 1884; GP/B/2/3/2/5, 17 September 1908.
[244] BCL, Incident Book, GP/B (ACC2009/109), box 15, 4 February 1886.
[245] King, pp.234-35.
[246] WALS, *WC*, 22 May 1895.
[247] WALS, WBG, PU/WOL/A/36, 21 November, 5 December 1913.

treated, especially by the lady supervising the epileptic ward, where he had been a patient.[248] Early in the twentieth century, Henry Yarwood also expressed his gratitude to the infirmary staff in Birmingham, who had 'pulled me through my long and dangerous illness'. He had spent 16 weeks in Birmingham infirmary in 1902 receiving treatment for Bright's disease, in what would have been an acute episode of a long-term renal disease. However, he had recovered sufficiently to return to playing his 'organette' and offered to do so without charge in the workhouse on Christmas day.[249]

Summary

Sick paupers were not identified as a distinct group within the poor law system before 1910 and not separated out in official statistics until 1913. Before that time, those who were temporarily disabled were counted within the able-bodied class, while the chronic sick were included among non-able-bodied paupers.[250] Thus, information regarding acutely ill inmates can only be gleaned from local studies, such as the present one. Significant medical activity took place in Birmingham workhouse's Town Infirmary prior to the NPL and in the years immediately following it. The surgeons had the right to admit patients without seeking the guardians' permission and were able to discharge almost half of those admitted, despite the guardians' inability to refuse admission to more complex or chronic cases. Furthermore, discharge would only be possible if the patient could be maintained at home through

[248] BCL, VGPC, GP/B/2/8/1/9, 26 September 1884.
[249] BCL, WIMC, GP/B/2/4/4/4, 15 December 1902; Bright's disease is a group of diseases characterised by inflammation of the kidneys and oedema of the lower body.
[250] Williams, p.203.

resumed employment or a measure of outdoor relief. Although the proportion of sick inmates in Wolverhampton workhouse was half that in Birmingham in the early years after the NPL, patients with a range of acute conditions were treated and the proportion matched Birmingham's by the mid-1840s. However, Birmingham workhouse experienced a much higher proportion of sick inmates than the national average for the whole of the period studied, reaching over half by the mid-1880s and before the new infirmary was opened. By comparison, Wolverhampton workhouse's proportion was more often similar to the country as a whole. One explanation could be the greater density of population in Birmingham as the towns were similar in respect of general health and cleanliness. Alternatively, it may have resulted from Birmingham's longer tradition of providing institutional poor law medical services and a more active medical profession in the town.[251]

The workhouse also provided care for those suffering from chronic illness and disability. The relative neglect of those in the bedridden wards in the guardians' records needs to be seen in the context of the medical model of disability prevalent in the nineteenth century. Furthermore, the special health needs of older and disabled patients remained unrecognised until the early twentieth century and chronic diseases did not arouse the interest of the medical profession, nor did it improve the profile of the infirmary to the same degree as acute illness.[252] Deborah Stone has suggested that interesting insights into the measurement of disability can be gained from study of English welfare policy and that disability as an administrative category arose from the classification system of the NPL. She asserted that the 'sick, aged and infirm' classes

[251] Chapters 1 and 4 provide further evidence of medical activity in Birmingham.
[252] Edwards, pp.230, 238; A. Levene, 'Between Less Eligibility and the NHS: The Changing Place of Poor Law Hospitals in England and Wales, 1929-39', *Twentieth Century British History*, 20 (2009), pp. 322-45.

are part of today's concept of disability.[253] WMOs were responsible for the assessment and allocation within the classification system and for determining inmates' ability to work. Poor law medical practice explains how the concept of disability became associated with clinical medicine and medical practitioners became 'gatekeepers for disability verification' in the twentieth century.[254]

Although the number of patients categorised as suitable for the bedridden wards in Birmingham increased considerably and extra accommodation was needed, their increase was in proportion to that of all types of inmate admitted to the workhouse. Their misplacement into other wards of the house was primarily driven by their number outstripping the available accommodation and there was no evidence that they were given lower priority in this respect than other groups of inmates. They were subject to a range of disability levels and suffered from the same chronic conditions as older patients in long-term institutional care today. What the records do not reveal is the nature of the medical care they received. They did make considerable demands on the MOs' time, but the level of nursing staff and pauper assistants allocated to the bedridden wards was of the same proportion as the other wards in the infirmary.[255] Less information is available relating to disabled inmates in Wolverhampton workhouse, but examination of the local records revealed that a substantial proportion of sick inmates were dependent. Surprisingly, many within the able-bodied class were considered unfit for work. However, using age as a surrogate for disability, the increasing number of dependent inmates reflected the rise in the admission of all

[253] D. Stone, *The Disabled State*, Philadelphia, 1984, pp.29-30, 51.
[254] S. Sneyder and D. Mitchell, 'Afterword - regulated bodies: disabled studies and the controlling profession', in Turner and Stagg (eds), *Social Histories of Disability and Deformity*, p.182; Turner, 'Introduction', p.8; Stone, p.28.
[255] BCL, Workhouse Inquiry Sub-committee, GP/B/2/3/11/1, 22 March 1878; VGPC, GP/B/2/8/1/5, 23 March 1866.

classes of pauper. David Thomson argued that the workhouse did not play an important role in the care of older people in the mid-nineteenth century because 'the aged formed a minor portion of any workhouse population' and played only a minor part in the actual day-to-day provision for an older population.[256] Nigel Goose has challenged this assertion as 'simply not acceptable' because of the findings in his study of workhouse populations in Hertfordshire.[257] The proportion of older inmates in Wolverhampton workhouse in mid-century (usually around a third) would also contradict Thomson's opinion.[258] This chapter has filled a gap in the narrative by considering the period at which state-organised and publicly funded institutional care for sick older paupers with chronic illness and disability commenced and explains why its status in the eyes of the providers remained low.

Birmingham was a good example of the dichotomy of care between the workhouse and its infirmary. By contrast, in Wolverhampton, the workhouse and infirmary remained integrated and no separation between acute and chronic care appears to have taken place. The process of the division of patients according to the nature of their illness continued through the next two decades, with increasing reluctance of the infirmaries to admit patients with chronic illness.[259] Concern has been expressed that in the early 1900s acute medicine 'was subordinating the needs of the aged and chronically ill patients' and that it hampered the later development of care for a number of disadvantaged groups, including 'the chronically sick, the elderly, the poor,

[256] D. Thomson, 'Workhouse to Nursing Home. Residential care of elderly people in England since 1840', *Ageing and Society*, 3 (1983), p.46; D. Thomson, 'The Welfare of the Elderly in the Past: A Family or Community Responsibility' in M. Pelling and R. Smith (eds), *Life, Death and the Elderly,* London, 1991, pp.207-8.
[257] N. Goose, 'Workhouse Populations in the Mid-nineteenth Century', *Local Population Studies*, 62 (1999), p.67.
[258] For a discussion of the role of the workhouse in the care of older paupers, see A. Ritch, 'English Poor Law Institutional Care For Older People: Identifying the "Aged and Infirm" and the "Sick" in Birmingham Workhouse, 1852-1912', *Social History Medicine*, 27 (2014), pp.64-85.
[259] R. Means and R. Smith, *From Poor Law to Community Care*, Bristol, 1998, p.19.

the disabled'.[260] This chapter has contributed a rare positive view of the character of medical care in the workhouse and of its role within the medical provision of local communities. In 1866, Birmingham's WMO considered that the majority of patients who died had been under medical treatment at home or in the local voluntary hospitals and had been sent in to the workhouse to 'have comfort in their last moments'.[261] However, a significant proportion (7%) of inmates remained in the workhouse for more than five years around that time, while the majority of deaths in Wolverhampton workhouse twenty years earlier were in children and young adults.[262] Although the workhouse did function as a locus for end-of-life care, acute medical treatment was a significant part of the medical activity that took place within the institution. One important aspect of that acute care was the management of patients with communicable diseases and this constituency will be addressed in the following chapter.

[260] R. White, *Social Change and the Development of the Nursing Profession*, London, 1978, p.120; C. Lawrence*, Medicine in the Making of Modern Britain, 1700-1920*, London, 1994, p.87.
[261] BCL, BBG, GP/B/2/1/33, 23 May 1866.
[262] BPP, 1861 (490), pp.194-95.

CHAPTER 3

THE SEGREGATION OF COMMUNICABLE DISEASE

'the workhouse…is the receptacle for all classes of disease.'[1]

Nineteenth-century Britain was characterised by epidemics and the widespread prevalence of infectious diseases, which were the commonest causes of morbidity and mortality.[2] Infectious diseases, excluding bronchitis and pneumonia, accounted for 33% of deaths in the years 1848-72 in England and Wales and one-third of those deaths were due to respiratory tuberculosis.[3] With the inclusion of non-tuberculous respiratory disease, Graham Mooney and colleagues calculated that 48% of deaths nationally in 1851-1860 were infectious.[4] Communicable disease was more prevalent in areas where people were crowded together. Rapid urban growth in the early nineteenth century, with its associated problems of sewerage and water supply, multiplied the risk of infection. Thus, urban environments became more unhealthy and allowed disease to become endemic.[5] According to Anne Hardy, there grew up within these areas 'fever nests', from where the Victorians feared that epidemics

[1] Birmingham Central Library (hereafter BCL), Birmingham Board of Guardians' Minute Book (hereafter BBG), GP/B/2/1/33, 23 May 1866.
[2] The major texts on non-tuberculous infectious diseases as a group include M. Pelling, *Cholera, Fever and English Medicine, 1825-1865*, Oxford, 1978; A. S. Wohl, *Endangered Lives, Public Health in Victorian Britain*, London, 1983; R. Woods and J. Woodward (eds), *Urban Disease and Mortality in Nineteenth-Century England*, London, 1984; A. Hardy, *The Epidemic Streets, Infectious Disease and the Rise of Preventive Medicine, 1856-1900*, Oxford, 1993; M. Worboys, *Spreading Germs, Disease Theories and Medical Practice in Britain, 1865-1900*, Cambridge, 2000; M. Dobson, *Disease, the Extraordinary Stories Behind History's Deadliest Killers*, London, 2007.
[3] W. P. D. Logan, 'Mortality in England and Wales from 1848 to 1947', *Population Studies*, 4 (1950), pp.138-40.
[4] G. Mooney, 'Infectious Diseases and Epidemiologic Transition in Victorian Britain? Definitely', *Social History of Medicine*, 20 (2007), p.600.
[5] Wohl, pp.3-4, Woods and Woodward, p.20.

could escape and spread to the rest of the population.[6] For example, Whitechapel was considered the 'nucleus of the metropolitan fever field', while Southwark held the same status within the cholera field in London.[7]

The mortality rate from infectious diseases declined markedly in the second half of the nineteenth century, both in absolute terms and in relative importance among all causes of disease. In 1901-10, they accounted for only 19% of all deaths.[8] This mortality decline was accompanied by an epidemiological transition, with degenerative diseases replacing pandemics of infection as primary causes of morbidity and mortality, a theory first proposed by Abdel Omran in 1971.[9] This shift in disease patterns, with a progressive decline in infectious diseases, began in the mid-eighteenth century, but showed a more marked fall in overall mortality rate in England and Wales from the mid-nineteenth century. The reasons for the mortality decline have been a contentious issue among historians and epidemiologists. [10] In western European societies, Omran ascribes the decline to socioeconomic factors, augmented by the sanitary revolution in the late nineteenth century.[11] The work of Thomas McKeown has been influential in stressing the primary reason as the improving nutritional status of the population.[12] However, Simon Szreter argues that preventive public health provision and services were more important in explaining the

[6] Hardy, p.1.
[7] *The Lancet*, 'Reports on the Old Cholera Haunts and Modern Fever Nests of London', ii (1865), p.656.
[8] Logan, pp.138-141.
[9] A. Omran, 'The Epidemiological Transition', *Milbank Memorial Fund Quarterly*, 49 (1971), pp.509-38.
[10] Detailed discussion of the epidemiological transition can be found in: G. Mooney, 'Infectious Diseases and Epidemiologic Transition in Victorian Britain? Definitely', *Social History of Medicine*, 20 (2007), pp.595-606; A. Hardy, *The Epidemic Streets, Infectious Disease and the Rise of Preventive Medicine, 1856-1900*, pp.1-11; T. McKeown and R. G. Record, 'Reasons for the Decline of Mortality in England and Wales during the Nineteenth Century', *Population Studies*, 16 (1962), pp.94-122.
[11] Omran, p.534.
[12] For example, in McKeown and Record, pp.94-122.

mortality decline.[13] Hardy's view is that no one factor was of overriding importance in reducing death rates, but the measures taken by the preventive authorities were of fundamental importance.[14] Indeed, the historiography of infectious diseases is most often set in the context of the general development of the public health movement, to the detriment of local studies of death and disease.[15] An integral component of preventive policy to combat infectious disease was the development of fever and smallpox hospitals to provide facilities for isolation.[16]

Although the Public Health Acts of 1866 and 1875 empowered sanitary authorities to build hospitals and permitted compulsory isolation of patients, the development of isolation hospitals by local authorities was slow. Only one-fifth had made any provision by the 1890s, although the smallpox epidemics gave a degree of impetus.[17] For instance, arrangements for fever in the Manchester region other than provided by guardians were present only in Manchester, Preston and Lancaster in the 1860s.[18] Additionally, until the 1880s, fever hospitals were small, usually containing around 70 beds.[19] The task of coping with patients with infectious disease fell to the poor law authorities and this provides the theme for this chapter. As the Edmund Robinson, medical officer (hereafter MO) at Birmingham workhouse, succinctly put it in 1866 'the workhouse as a matter of course is the receptacle for all classes of disease'.[20]

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[13] S. Szreter, 'The Importance of Social Intervention in Britain's Mortality Decline c.1850-1914', *Social History of Medicine*, 1 (1988), p.2.
[14] Hardy, pp.290-92.
[15] Ibid., pp.2-3.
[16] Ibid., p.5.
[17] Wohl, p.138; J. V. Pickstone, *Medicine and Industrial Society: a history of hospital development in Manchester and its regions 1752-1946*, Manchester, 1985, pp.156, 158; M. Currie, *Fever Hospital and Fever Nurses: A British Social History of Fever Nurses: A National Service,* London, 2004, pp.13, 125-26.
[18] Pickstone, p.160.
[19] F. B. Smith, *The People's Health 1830-1910*, London, 1979, p.241.
[20] BCL, BBG, GP/B/2/1/33, 23 May 1866; this quote appears in the heading to the chapter.

This chapter will consider the arrangements for admitting paupers with infectious diseases to either the workhouse infirmary or the local isolation hospital and will explore the extent of co-operation between the guardians and the sanitary authorities or town councils. How local outbreaks of epidemic disease were managed and how many patients with infectious disease were admitted to the poor law facilities will be analysed. It will address the following questions: how important was the medical role of the workhouse within the local communities; to what extent did Birmingham and Wolverhampton follow national developments in the prevention of infection; were poor law medical facilities an essential component of the management and treatment of communicable diseases in the nineteenth and early twentieth centuries? They will be considered from the standpoints of the impact of a number of childhood infections; the outbreaks and epidemics of cholera, typhoid and smallpox; and the prevalence of endemic diseases, such as typhus and tuberculosis. However, it is first necessary to consider the issue of fever in general.

Isolating Fever Patients

The most striking manifestation of infectious disease was fever, which remained acceptable as a diagnosis in the late nineteenth century. Cullen in the later part of the eighteenth century identified three stages of fever, as debility, chill and heat, and defined it as a disease in itself when it was not associated with another identifiable disease process.[21] In the 1860s, it was classified clinically according to the temperature pattern into acute, intermittent or continuous types, while the presence of

[21] W. F. Bynum, 'Cullen and the Study of Fevers in Britain, 1760-1820', *Medical History,* Supplement, No. 1 (1981), p. 138.

a rash would aid a more precise diagnosis.[22] In English and Welsh workhouses in 1870, a one-day survey of inmates under the care of MOs revealed that 25% of those with infectious disease were identified by the type of fever only.[23] Furthermore, 12% of sick inmates suffered from a communicable condition.[24]

The need for isolation facilities for inmates with infectious disease was recognised from the early eighteenth century and some workhouses set aside special wards for the isolation of infectious cases.[25] However, it was not until the late 1860s that provincial workhouses provided a detached building for the isolation of inmates with infective conditions.[26] For example, Battle workhouse in Reading, erected in 1867, could accommodate fever cases in a small, detached building, which was enlarged three years later to hold 24 patients. Although the guardians agreed that non-paupers with infectious diseases could be admitted to the workhouse fever wards, a girl aged 25 with smallpox refused admission in 1876 because of the stigma of pauperism. The local sanitary authorities did not erect an isolation hospital until after a smallpox outbreak in 1880, while the guardians erected an additional isolation facility, the 'Infectious Hut Hospital', in 1881, consisting of two wards, each with three beds.[27] However, the significant role of provincial workhouses in caring for patients with infectious disease and in providing additional facilities to cope with epidemics has been largely neglected. The historiography of institutions for infectious diseases is sparse and has concentrated on isolation hospitals, especially those established in

[22] K. D. Keele, 'Clinical Medicine in the 1860s' in F. N. L. Poynter (ed.), *Medicine and Science in the 1860s*, London, 1968, p.7.
[23] By contrast, only 2% of patients in Birmingham had fever and all were grouped under the generic term; there were no fever patients in Wolverhampton workhouse. British Parliamentary Papers (hereafter BPP), 1870 (468-I), pp.52, 82, 86, 232, 236.
[24] Ibid., pp.3, 52-53, 57.
[25] K. Morrison, *The Workhouse A Study of Poor-Law Buildings in England*, Swindon, 1999, p.156.
[26] Ibid., p.169.
[27] M. Railton and M. Barr, *Battle Workhouse and Hospital 1867-2005*, Reading, 2005, pp. 57-59.

London, following the Metropolitan Poor Act 1867 (hereafter MPA). The act set up the Metropolitan Asylum Board to manage isolation hospitals and lunatic asylums, rather than local boards of guardians, and provided centralised funding from the capital's poor rates. This system of care for infectious diseases remained unique to London. Gwendoline Ayers' major work is devoted to the general development of the board's hospitals and asylums, but contains limited information on any one institution.[28] Provincial English isolation hospitals have been neglected within historical accounts and the one substantial history concerns the institutions for fever patients in Edinburgh. However, in *The Edinburgh City Hospital*, James Gray puts the emphasis on the medical men who ran the institution.[29] Workhouse histories contain only brief reference to isolation facilities. For instance, Margaret Railton and Marshall Barr devote only five pages to infectious diseases in their study of Battle workhouse and mention only occasional admissions, so that it is difficult to determine the workhouse's impact on medical care.[30] The history of tuberculosis has been the subject of a number of monographs, which testify to the role played by poor law infirmaries. However, they too are lacking in detail regarding the significance of the contribution by the infirmaries, both in terms of the extent of accommodation provided and the treatment regimes used.

Thirty years before the MPA, the MO of Wolverhampton Union workhouse called for a detached building to isolate inmates with infectious diseases, as he was apprehensive that typhus fever affecting a woman in the lying-in ward might rapidly

[28] G. M. Ayers, *England's First State Hospitals and the Metropolitan Asylums Board 1867-1930*, London, 1971.
[29] J. A. Gray, *The Edinburgh City Hospital*, East Linton, 1999.
[30] Railton and Barr, pp. 96-98, 125-27.

spread throughout the workhouse.[31] Although new fever wards were provided, they had become so overcrowded five years later, that beds had to be pushed together to allow three inmates to sleep in two beds. This followed a marked increase in the number of 'fever patients' admitted, for instance in the midsummer quarter in 1847, patients suffering from fever constituted 66% of the 593 patients admitted.[32] A larger building accommodating between 40 and 50 patients with infectious disease was needed 20 years later.[33] In 1847, the MOs in Birmingham workhouse were also calling for immediate separate provision for fever cases, because of overcrowding so that in some instances, two patients occupied the same bed. In the summer of that year, 130 patients were suffering from 'contagious fever' out of a total of 345, and the majority were Irish. The likely cause was typhus and one district surgeon, three nurses, seven pauper assistant nurses and the schoolmaster all died of the infection.[34] As a result, the guardians purchased property adjacent to the workhouse to provide accommodation for 120 patients.[35] In the early 1850s, patients diagnosed with 'fever (mild)' constituted from 10% and 30% of those admitted with infectious diseases.[36]

Detached buildings for the admission of patients with fever and infectious disease, separate from the main infirmary were included in the plans for the second Birmingham workhouse erected in 1852 (Appendix H).[37] However, twelve years later, the workhouse medical officer (hereafter WMO) declared these wards inadequate 'according to the advanced state of sanitary science', as they were too

[31] Wolverhampton Archives and Local Studies (hereafter, WALS), Master's Journal (hereafter MJ), PU/WOL/U2, 20 March 1842.
[32] WALS, Wolverhampton Board of Guardians' minutes (hereafter WBG), PU/WOL/A/6, 29 January 1847; *Wolverhampton Chronicle* (hereafter *WC*), 20 September 1847.
[33] WALS, WBG, PU/WOL/A/12, 1 September 1864; DX/673/66.
[34] BCL, BBG, GP/B/2/1/5, 8 March, 12 October, 28 October 1847.
[35] BCL, BBG, GP/B/2/1/5, 20 April 1847.
[36] The National Archives (hereafter TNA), MH12/13297-99, 13300.
[37] J. A. Langford, *Modern Birmingham and its Institutions*, Birmingham 1871, pp.381-82.

close to the general infirmary and had to be accessed via the workhouse. He suggested two wards built 'side by side' to give efficient ventilation and these provided 50 beds for each sex when built two years later.[38] When the second workhouse in Wolverhampton opened in 1903, it also had two wards for 20 patients of each sex with infectious disease within the infirmary buildings, which were designed on the pavilion style (Appendix J). There was an additional 'Isolation Hospital' with two two-bedded wards, two nurses' rooms and three single bedrooms (Appendix K).[39] However, little information is available on the arrangements for infectious patients in the separate infirmary built on the site of Birmingham workhouse in 1889, although the 'infectious wards' were allocated a larger area per patient than the general wards.[40]

Childhood Infections

Susceptibility to infectious diseases was accepted as an inevitable part of childhood in Victorian Britain and institutional care would rarely have been considered necessary for the management of the disease process. The infections that were responsible for most of childhood morbidity and death in nineteenth-century Britain were measles, whooping cough, scarlet fever and diphtheria. They were highly transmittable diseases, by personal contact with infected individuals or by airborne droplets, had high fatality rates and were common in crowded conditions, such as schools and workhouses. The most contagious was measles, a viral infection, which almost

[38] BCL, Visiting and General Purposes Committee (hereafter VGPC), GP/B/2/8/1/4, 17 June 1864; GP/B/2/8/1/5, 22 May 1865; BPP, 1867-68 (4), facing p.46.
[39] WALS, *Wolverhampton Journal Illustrated*, vol. II, LS/LO7/79, p.liv; New Wolverhampton Workhouse, DX/120/10/4; DX/120/10/8; DX/120/10/9.
[40] BCL, B. Col. 41.11, Miscellaneous Documents, vol. 4, 'Report in reference to the New Workhouse Infirmary', p.18.

always produced clinical disease in those infected.[41] Secondary bacterial infection was responsible for 80% of deaths and could result in long-term disability in those who survived.[42] The mortality rate was highest in the first two years of life and remained unchanged throughout the century.[43] Little action was taken to reduce the death rate until the 1880s, but even then, it was unaffected by preventive services. It was also highest in large towns, as the disease required a certain density of population to become established as endemic.[44] Its prevalence and severity in any one community also may have related to the degree of overcrowding and the level of malnutrition.[45]

Birmingham guardians were concerned that Bridget Hunt's children, who had been admitted to the workhouse with their mother in 1856, were suffering from measles, despite being detected by the WMO prior to admission. They urged that 'infectious cases' should be managed on outdoor relief, no doubt fearful of rapid spread of the infection within the institution.[46] However, an outbreak of measles occurred in the workhouse twenty years later, with 65 admissions within nine months. The Children's Hospital also admitted 48 sufferers, as the Borough isolation hospital could not accept admissions.[47] Thereafter, a small number of cases were usually present up to 1911, even though the majority of children had resided in Marston Green Cottage Homes from 1880 (Appendix A). However, the year before they were transferred, there were 40 cases of measles on one day in March, representing 6% of children in the

[41] The infecting organism is a paramyxovirus, causing respiratory infection, with fever and a rash; secondary bacterial complications affected the lungs and ears.
[42] Hardy, p.43.
[43] Ibid., pp. 9, 29.
[44] Ibid., p.29; Dobson, p.140.
[45] Hardy, p.34.
[46] BCL, BBG, GP/B/2/1/19, 17 December 1856.
[47] BCL, VGPC, GP/B/2/8/1/6, 6 October 1876; TNA, MH12/13326, MOH's report for 1876.

workhouse.[48] The largest numbers admitted between 1880 and 1911 occurred in the Lady Day and Midsummer quarters, reflecting the peak incidence of the disease in the spring. In four months in early 1886, 30 cases were admitted and in the first half of 1907, there were on average six cases in the infirmary.[49] For the year ending on 31 May 1910, 19 cases of measles were admitted to the infirmary out of a total of 3,338 patients.[50] In contrast, the presence of measles in Wolverhampton workhouse was only noted when three inmates suffered from the disease in February 1864 and a similar number in March 1891.[51] Yet, the disease was prevalent in the Borough of Wolverhampton. For example, between 1884 and 1889 reported cases varied between 300 and 1,100, with a median mortality rate of 6%, slightly higher than the national rate of around 4.5%.[52] Similarly, only two cases were recorded in any of the workhouses in the county of Worcestershire between 1834 and 1871 and both occurred in Droitwich, one in 1859 and the other ten years later.[53] The reason why sufferers from measles were not often found in workhouses may have been because poor parents rarely sought medical attention for their affected children.[54]

The other highly contagious infection that was regarded as an almost universal experience in childhood and was not subject to substantial preventive action throughout the nineteenth century was whooping cough, now known as pertussis.[55] It was the next most frequent cause of infant mortality after measles. The infection began with a catarrhal period, during which airborne transmission made it highly

[48] BCL, LGB Returns, GP/B/8/5/1/1, 29 March 1879.
[49] BCL, Incident Book, GP/B/(Acc 2009/109), Box 15, 12 May 1886; LGB Returns, GP/B/5/1/7, 5 January to 30 March, 1907.
[50] BCL, Infirmary Management Committee (hereafter IMC), GP/B/2/4/4/5, 11 July 1910.
[51] WALS, *WC,* 10 February 1864; 18 March 1891.
[52] TNA, MH12/11721, H. Malet, 'Annual Report of Health of Wolverhampton for 1898'; Smith, p.143.
[53] F. Crompton, *Workhouse Children*, Stroud, 1997, p. 90.
[54] Smith, p.146; Hardy, p.28.
[55] Hardy, p.9.

contagious. Thereafter, paroxysms of coughing developed, ending with a stridulous inspiratory 'whoop'.[56] When John Edwards, his wife and six children applied to enter Wolverhampton workhouse in 1843, the MO confined them to the receiving ward so that they could be considered for out relief. The children had been diagnosed as having whooping cough and he wished to prevent it spreading throughout the institution.[57] Despite no further mention in the workhouse records, whooping cough was a significant cause of death among infants in Wolverhampton in the 1890s, most frequently accounting for around 1% of deaths in children less than six years of age in the first quarter of each year. In some years, mortality was much greater; for instance, 8% in 1892, 9% in 1890 and 18% in 1892.[58] This mortality rate was greater than the 0.3% for England and Wales in the 1890s.[59] However, the Wolverhampton rate is for the quarter of the year with the highest incidence, rather than for the whole year. The disease also gets no mention in the Birmingham guardians' records, despite being the most common childhood infection in the infirmary and being prevalent for the whole of the period covered in Appendix A. The only recorded cases in Worcestershire workhouses were in 12 children affected in an outbreak in Droitwich in 1868.[60] As with measles, parents did not feel the need to seek medical attention for the condition and the preventive authorities did not promote isolation in institutions. Nevertheless, unlike measles, sufferers were admitted to Birmingham workhouse.

[56] The causative organism is a small rod-shaped bacterium, *Bordetella pertussis*. The paroxysmal coughing is mediated via the production of toxin and can result in apnoeic attacks in infants.
[57] WALS, MJ, PU/WOL/U2, 18 November 1843.
[58] TNA, MH12/11721, H. Malet, 'Annual Report of Health of Wolverhampton for 1898'.
[59] Hardy, p.10.
[60] Crompton, pp.90-91.

One of the other great killers of very young children was scarlatina, or scarlet fever.[61] It was one of the most difficult diseases to diagnose clinically in its early stages and there was no diagnostic test.[62] Different strains of the bacteria have varying degrees of virulence and a more virulent strain became prevalent after 1830, leading to eight epidemics in the subsequent five decades.[63] The severe local epidemics, which occurred frequently, were usually associated with infected milk.[64] A milder strain re-appeared toward the end of the century, but epidemics continued into the next, occurring in 1901, 1907 and 1914. Nevertheless, the fatality rate fell by almost 50%, from 49% in the ten years after 1895, to 26% in the next decade. [65] In the epidemics in the 1860s and 1870s, the greatest number of deaths occurred in London, northern industrial cities and the Black Country.[66] In Wolverhampton, in the first quarter of each year in the 1890s, the mortality rate among children less than six years old was usually between 1% and 3%, although, in 1895, it was almost 8% (17 deaths).[67] The fatality rate for all ages in that decade was between 3% and 6%, whereas, in the mid-1880s, it was considerably higher at between 9% and 19%.[68] The mortality rate in England and Wales fell dramatically in the 1860s and had reduced by 81% by 1891.[69] The reduction was due to a combination of reduced virulence of the organism and measures to control the spread of infection. The disease was one of the first to have an active preventive policy applied to it, in the form of institutional isolation,

[61] It is caused by a haemolytic streptococcal bacterium, *Streptococcus pyogenes*, which can also produce tonsillitis and erysipelas. Scarlet fever is the response to the toxin produced by the organism and results in widespread erythema of the skin.
[62] Worboys, p.262.
[63] Hardy, p.59.
[64] Smith, p.137.
[65] Ibid., p.65.
[66] C. Creighton, *A History of Epidemics*, Vol. 2, London, 1965, pp.727-28.
[67] TNA, MH12/11721, H. Malet, 'Annual Report of Health of Wolverhampton for 1898', p.17.
[68] Ibid.
[69] Smith, p.137.

especially after the development of infectious disease hospitals from the 1870s.[70] Beds in these hospitals came to be dominated by scarlet fever patients by the end of the century; for example, they were the largest group in the City Fever Hospital, Edinburgh between 1888 and 1892 and again in 1904, when the 942 admissions, with a fatality rate of just below 3%, constituted 33% of all patients.[71] However, the decline in mortality was mainly due to a decrease in the virulence of the organism.[72]

Wolverhampton guardians took measures to prevent outbreaks in the workhouse by restricting visiting when scarlet fever was prevalent in the town in the 1870s and 1880s.[73] In the following decade, they arranged for cases to be admitted to Wolverhampton Borough Hospital for infectious diseases for a payment of 2s and 6d per patient per day.[74] There are no further reports of patients with scarlet fever remaining in the workhouse, but 1,215 patients with scarlet fever were treated in the hospital between 1888 and 1892.[75] Birmingham guardians took a different approach in 1889, allowing the town's health committee to use a building, previously employed as a test workhouse for able-bodied men, for children convalescing after a bout of scarlet fever, as they would no longer be infectious. The move released 30 to 40 beds in the town's isolation hospital.[76] Over the years 1877-80 and 1894-1911, only one case of scarlet fever was recorded in the workhouse (on 29 June 1895), but the numbers are one-day counts on only a few days in the year and may not represent the overall prevalence for those years. In addition, the isolation hospital in Lodge Road

[70] Hardy, p.56.
[71] Pickstone, pp.158-59; Gray, pp.65, 148-49.
[72] J. Woodward, 'Medicine and the city: the nineteenth century experience', in R. Woods and J. Woodward (eds), *Urban Disease and Mortality in Nineteenth-Century England*, London, 1984, p.68.
[73] WALS, WBG, PU/WOL/A/17, 19 October 1777; PU/WOL/A/20, 26 March 1886.
[74] WALS, WBG, PU /WOL/A/25, 13 December 1895.
[75] BPP, 1895 (28), p.354.
[76] BCL, WMC, GP/B/2/3/2/1, 28 May 1889.

had been admitting patients with scarlet fever from 1875, with 424 admissions that year. In 1882 they increased to 627 and, in the four years from 1888, they treated 7,206 patients, including 2,525 in 1890.[77] However, these patients continued to be admitted to the workhouse infirmary; for instance, six cases in a four-month period in 1886 and five in the twelve months to 31 May 1910.[78] In summary, the co-operation between the guardians in both towns and the sanitary authorities ensured that as few patients as possible with scarlet fever were admitted to the poor law institutions.

As scarlet fever waned in virulence toward the end of the century, diphtheria took its place as a major killer of young children. It had only become recognised in England as a distinct disease entity in mid-century after an epidemic of throat-disease in 1858. Prior to that time, it had been included in mortality statistics under scarlatina.[79] The disease results in inflammation and severe swelling in the upper airways, which can cause obstruction and death by respiratory failure. It is spread by droplet infection following direct contact with cases or carriers. The main form of management was strict isolation in hospital to limit spread of infection, but this had little effect on the mortality from the disease. By the middle of the 1890s, the organism could be isolated from throat swabs, aiding accurate diagnosis, and anti-toxin was available to counteract the systemic effects on the heart and nervous system.[80] However, to be effective anti-toxin had to be administered within the first four days of the illness, when symptoms were not pathognomonic of diphtheria. Furthermore, it was expensive and not provided free of charge by the sanitary authorities in Birmingham

[77] BPP, 1895 (28), p.402; TNA, MH/13365, 'Health of the City', pp.49-51.
[78] BCL, Incident Book, GP/B (ACC2009/109), box 15; IMC, GP/B/2/4/4/5, 11 July 1910.
[79] Creighton, p.736; Hardy, p.80. The causative organism is *Corynebacterium diphtheriae*, which affects the pharynx and larynx, with resultant membrane formation, and produces a toxin, causing cardiac damage and neurological lesions. There were three strains of the bacterium, namely *gravis, intermedia* and *mitis*, with case fatality being highest in the first and lowest in the last.
[80] Pickstone, p.159.

until 1902.[81] Nevertheless, throat swabbing and anti-toxin helped to check the spread of the disease and contributed to the rapid reduction in mortality, although a decline in virulence may also have occurred. It was the only disease in the nineteenth century that was affected by the germ theory and that preventive measures linked laboratory investigations, clinical practice and public health action in a co-ordinated way.[82]

The incidence of diphtheria in Birmingham had declined markedly after 1873, but a sudden increase in deaths occurred in 1895 (mortality rate, 0.33 *per* thousand of the population), compared with the year before (0.1 *per* thousand). Notified cases did not increase to the same extent (from 316 in 1894 to 640 the following year).[83] However, admissions to the workhouse did not take place until five years later and continued sporadically through the 1900s (Appendix A). In addition, there was an outbreak in the female epileptic wards in 1912.[84] According to F. B. Smith, Birmingham had the reputation as a 'notoriously bad' diphtheria town.[85] However, a large increase in cases occurred also in Wolverhampton in 1895 (308, compared with 82 the year before) and they remained at that level for the following two years. By contrast, the fatality rate was lower in 1895 (27%, compared with 40% in 1894) and it fell to 8% by 1897.[86] The mortality rate among children under six years old was 2% or less in the first half of the 1890s, but increased to between 6% and 11% after 1894.[87] An outbreak occurred in Wolverhampton workhouse in December 1896, with the disease affecting eight boys, of whom one died, and nurses Hilton, Riley, Whittaker and Wright over the following three months. The boys were isolated in a ward away from

[81] Smith, p.151; A. Hill, 'Reports of Medical Officers of Health', *The Lancet*, ii (1902), p.178.
[82] Pickstone, p.159.
[83] A. Hill, 'Remarks on the Incidence of Diphtheria in Birmingham', *Public Health*, 8 (1895-96), p.342.
[84] BCL, BBG, GP/B/2/1/81, 20 November 1912.
[85] Smith, p.151.
[86] TNA, MH12/11721, H. Malet, 'Annual Report of Health of Wolverhampton for 1898'.
[87] Ibid.

other children and the nurses in their rooms. The MO raised concerns over the condition of the lavatories attached to the wards where the disease had begun and requested measures to improve the drainage.[88] It is surprising that the disease was being linked to sanitary issues at that time, as the bacterium had been discovered in 1883 and the toxin had been in use in Britain since 1894. However, Hardy comments that bacteria were not fully accepted as the cause of the disease in England until the mid-1890s.[89] The Medical Officers of Health (hereafter MOsH) for Birmingham and Stoke Newington believed, at that time, that insanitary conditions were a predisposing cause of the disease due to the release of sewage gases.[90] The Medical Officer of Health (hereafter MOH) for the County of Fife also held that sewer gases were a vehicle for the spread of diphtheria and more attention needed to be paid to improving sanitary conditions, rather than dwell on the 'bacterial equation'.[91] A more enlightened approach was taken by the members of the Workhouse Visiting Committee in Wolverhampton at that time when they instructed the MO to send throat secretions to London for examination if more cases of diphtheria arose.[92] He did not do so during that outbreak, but the following year he sent secretions from the throat of nurse Rogers for analysis and the charge of 5s and 9d was approved.[93] At that time, laboratory testing remained concentrated in the capital and no facilities for the detection of diphtheria were available in large cities such as Birmingham.[94]

[88] WALS, WBG, PU/WOL/A/26, 29 January, 5 February, 19 February, 26 February 1897; TNA, MH12/11715, 6 January, 10 February, 1 March 1897.
[89] Hardy, p.84.
[90] Hill, 'Incidence of Diphtheria', pp.342-43; H. Kenwood, Notes on the Origin of Diphtheria', *Public Health*, 8 (1895-96), p.344.
[91] T. G. Naysmith, 'The Relation of Diphtheria to Insanitary Conditions', *Public Health*, 8 (1895-96), pp.4-5.
[92] WALS, Workhouse Visiting Committee (hereafter WVC), PU/WOL/H/2, 1 January 1897.
[93] Ibid., 25 November 1898.
[94] Worboys, *Spreading Germs*, p.262.

Table 3.1: Prevalence of Communicable Diseases in Britain in Nineteenth and Early Twentieth Centuries

Disease	Prevalence
Measles	Endemic, with epidemic in 1807-8; highly contagious; mortality unaltered
Whooping Cough	Endemic; mortality unaltered
Scarlet Fever	Endemic; more virulent strain from 1830-80, with epidemics in 1840, 1844, 1858-59, 1863-64, 1868-71; milder from 1890s, with increased prevalence in 1901-14 with lower mortality
Diphtheria	Endemic after epidemic in 1858-59; mortality declined in twentieth century
Typhus	Epidemics in 1817-18, 1837-38, 1846-47, 1869-70; endemic in urban areas; mortality declined after 1870; disappeared by end of nineteenth century
Typhoid	Separately identified as a disease in 1869; endemic; mortality declined in 1880s
Cholera	Epidemics in 1832, 1848-49, 1853-54, 1865-66
Smallpox	Endemic; epidemics in 1817-19, 1825-26, 1837-40, 1871-72, 1884-85 of *Variola major*; milder strain, *Variola minor*, with epidemics in 1892-93, 1901-2
Tuberculosis	Endemic; mortality declined towards end of nineteenth century

Childhood infectious disease occurred in workhouse infirmaries to a variable extent, but measles and whooping cough were rarely absent, as was diphtheria from the end of the century. In the main, they were managed in the workhouse without difficulty and so are mentioned in the records infrequently. It was in the early years after the NPL that guardians were concerned that childhood infection might spread throughout the workhouse because of a lack of appropriate isolation facilities. In the majority of outbreaks, the guardians and MOs took steps to manage the situation appropriately. Scarlet fever was a different matter, where guardians in Wolverhampton and

Birmingham sought to make arrangements for admission to the local isolation hospitals. However, isolation facilities were not in place until later in the century and, until then, workhouses had to shoulder the burden of caring for sufferers from infectious disease. In Wolverhampton in 1891, the lack of an isolation hospital meant that all cases of infectious disease were treated at home, except for two patients with scarlet fever, who were admitted to the workhouse.[95] Until isolation policies were introduced, children would not have been admitted to medical institutions primarily because of their illness if they could have been looked after at home. It is more likely that infection was coincidental to their admission with their parents or contracted while in the workhouse.

Diarrhoeal and Dirt Diseases

Workhouses were the obvious locus of institutional care for paupers suffering from diseases associated with poverty and guardians responded to the demand by adopting varying strategies to cope with the influx or to divert it to other facilities. Typhus and typhoid fever are linked as 'so-called' dirt diseases since they flourish in conditions of poverty, overcrowding, uncleanliness and poor personal hygiene.[96] Typhus is transmitted to humans from body lice, is contracted by the inhalation of contaminated dust, resulting in fever, headaches and a purpuric rash, and had a case fatality rate of 20-45%.[97] However, louse transmission was not demonstrated until 1909 and medical men remained in 'total ignorance' of the nature and origins of typhus throughout the

[95] TNA, MH12/11711, MOH's report for 1891.
[96] B. Luckin, 'Evaluating the sanitary revolution: typhus and typhoid in London, 1851-1900', in R. Woods and J. Woodward (eds), *Urban Disease and Mortality in Nineteenth-Century England*, London, 1984, p.118.
[97] Hardy, pp.192, 210. The causative organism, *Rickettsia prowazekii*, is excreted in the faeces of the body louse and can survive in them for many months.

nineteenth century.[98] Nevertheless, by the 1860s, it was accepted as a contagious disease, associated with destitution and overcrowding.[99] Consequently, typhus was endemic in urban areas, but two major epidemics, which were less dependent on domestic and working conditions, occurred in the nineteenth century in the years 1837-38 and 1846-47. The first caused the deaths of 75 individuals in Birmingham in the second half of 1837 and 45 in Wolverhampton.[100] The latter one reached England from Ireland at the time of the famine and was referred to as the 'Irish fever'. Over 17,000 people died in England and Wales from typhus in that year, following which the number declined to under 1,000 by 1878 and less than 250 by 1886. By the end of the century, it had virtually disappeared. The decline of the disease has been attributed to rising living standards, improved sanitary conditions and better personal hygiene, as well as the isolation in hospital of infected families, which allowed the opportunity of disinfecting their homes.[101]

It was liable to cause outbreaks in crowded institutions; hence its pseudonyms of 'jail fever', 'hospital fever' and 'workhouse fever', the last because of its prevalence in eighteenth-century workhouses.[102] After its appearance in Birmingham workhouse in 1847, there were usually a few cases present over the following decade (Appendix B). A few infected patients were admitted in Wolverhampton workhouse in 1842, one of which caused the lying-in ward to be closed for a month. Two years later, Ann Morris was brought to the workhouse in an open cart suffering from typhus, with

[98] Ibid.
[99] Ibid., p.194.
[100] Creighton, p.195.
[101] Hardy, p.204; Luckin, p.111.
[102] Dobson, p.36; K. Siena, 'Contagion, Exclusion and the Unique Medical World of the Eighteenth-Century Workhouse', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse*, Rochester, 2013, p.27.

'high state of fever and delirium', but the MO detained her in the receiving room.[103] On one day in December 1869, the only patients in the workhouse with infectious disease were 25 with typhus and they constituted 10% of all patients. By contrast, no patients in Birmingham workhouse suffered from the disease on that day and only 325 did so in all the English and Welsh workhouses.[104] It is surprising that so little is recorded about infection with typhus in the workhouse, as admission of infected paupers in the 1860s usually led to severe outbreaks within workhouse infirmaries in London.[105] It is possible that the practice of removing the clothes of inmates and subjecting them to bathing on admission may have limited the spread of body lice to other inmates.

Typhoid, a type of enteric fever, was not identified in annual registration reports as a separate disease distinguishable from typhus until 1869, although the clinical differentiation between the two had been widely accepted in Britain by the medical profession following Jenner's studies of the disease in the 1840s.[106] Like typhus, it presents with fever, headache, a rash and diarrhoea.[107] The disease is contracted by ingestion of food or water contaminated by human faeces; hence its reputation as the 'filth disease' was due to its association with faecal pollution. Despite this, it affected all social classes as the houses of the wealthy had private wells and poor drainage, as was the case in Birmingham.[108] The responsible bacterium was discovered by Karl

[103] WALS, WBG, PU/WOL/1/15, 24 March 1842; MJ, 26 March 1842 and 26 October 1844.
[104] BPP, 1870 (468-I), pp.52, 63, 82, 86, 233, 286.
[105] Anonymous, 'Reports on the Old Cholera Haunts and Modern Fever Nests of London', *The Lancet*, ii (1865), p.656.
[106] Creighton, p.213; Worboys, p.132.
[107] The rash is typically rose-coloured and spotted and appears later in the course of the disease. It is associated with the diarrhoea and may be followed by intestinal ulceration.
[108] Wohl, p.278; Pelling, pp.197, 283; R. Woods, Mortality and sanitary conditions in late nineteenth-century Birmingham', in R. Woods and J. Woodward (eds), *Urban Disease and Mortality in Nineteenth-century England*, London, 1984, pp.197-98.

Eberth, a German bacteriologist, in 1880.[109] However, its acceptance as the definitive cause of typhoid was not universal in Britain until the emergence of a diagnostic test in 1896 and a vaccine the following year.[110] Although endemic in England, outbreaks took place in the 1820s, 1840s and 1870s. Mortality from typhoid declined substantially from 0.85 per thousand at that time until the early 1880s (to 0.21) and continued to decline slowly until the end of the century.[111] For instance, in Birmingham Registration District, it was halved between the decades 1871-80 and 1901-10, falling from 788 deaths and a death rate of 0.33 per thousand to 351 and 0.15 respectively; figures similar to the national picture.[112] The major factors in achieving this change were improved domestic water supply and better individual hygiene, but the more stringent hospitalisation of patients was also important.[113] The MOH for Birmingham attributed the decline in cases of enteric fever predominantly to the provision of isolation accommodation.[114]

An outbreak of typhoid occurred in a house in Oxford Street, Wolverhampton in 1869 and the 11 sufferers who survived were admitted to the workhouse. They joined five existing patients with the disease, causing the female fever wards to be fully occupied.[115] However, typhoid does not appear in the poor law records of Wolverhampton and Birmingham until the 1880s. An outbreak occurred in the town of Bilston in the Union of Wolverhampton in 1885, and the guardians arranged for infected paupers to be admitted to the local isolation hospital. Despite this, two inmates died from typhoid in the workhouse the following year, as well as four in the

[109] Known as *Salmonella typhi*, it is excreted in human faeces.
[110] Worboys, pp. 268-69.
[111] Smith, p.245; Luckin, p.107.
[112] Woods, p.181; Hardy, p.152.
[113] Hardy, pp.152-53, 159, 165; Wohl, p.128.
[114] *The Lancet*, 'Reports of Medical Officers of Health', ii (1902), p.178.
[115] WALS, *WC,* 24 November 1869.

General Hospital.[116] In 1892, when Elizabeth and Ellen Brooks arrived at the workhouse suffering from typhoid, it was the General Hospital that the guardians turned to for their admission, agreeing to meet the cost of their care.[117] Despite this, patients with typhoid continued to be admitted to the workhouse, as there were four present three years later in March.[118] A small number of inmates with typhoid were also present in Birmingham workhouse throughout the 1870s, 1880s and 1890s (Appendix A). Prior to 1882, they were being treated in the general sick wards, but, in that year, the guardians decided they should be isolated from other patients and agreed to convert the room over the 'old swimming bath' for this purpose.[119] Three years later, the bed provision for typhoid patients was eight for men and, surprisingly, none for women, although they would have been able to reside in the 12-bedded, female infectious ward.[120] Only one inmate is recorded as having typhoid after midsummer 1899 (Appendix A), but, as the figures are based on one-day counts, it might reflect the reduced prevalence of the disease rather than its non-existence in the workhouse. However, there were no cases of typhoid between October 1906 and the same month two years later. The opening of a second isolation hospital in the city at Little Bromwich in 1895 may be a further reason for the lack of patients admitted to the workhouse. Furthermore, patients with typhoid did get admitted to the infirmary in the early twentieth century. Jordan Lloyd, visiting surgeon to the infirmary, complained in 1908 that two or three cases of the disease had been transferred from the workhouse into his wards and he believed that the visiting physician had had the

[116] WALS, WBG, PU/WOL/A/20, 21 and 28 August 1885; WALS, L614, Report on the Health of the Borough of Wolverhampton, for the year 1887, p.12.
[117] WALS, WBG, PU/WOL/A/24, 12 August 1892.
[118] WALS, *WC*, 20 March 1895.
[119] BCL, VGPC, GP/B/2/1/8//1/8, 28 April, 12 May 1882.
[120] BCL, VGPC, GP/B/2/8/1/9, 14 August 1885.

same experience.[121] In the same week, Miss Emma King, assistant matron of the workhouse and a qualified nurse, contracted the disease, was admitted to the nearby City Fever Hospital, but died ten days later.[122] These occurrences are suggestive of an outbreak in the workhouse at that time, but no cases of typhoid were recorded in the returns to the Local Government Board (hereafter LGB) for that month. Epidemics within workhouses could result in high fatality rates, such as the outbreak of enteric fever in Bridgewater parish workhouse in the winter of 1836-37 that killed one-third of inmates.[123] From the available literature, it appears that, in contrast to Birmingham and Wolverhampton, workhouses had very few if any inmates suffering from typhoid. However, inmates with severe infective diseases were more likely to die within the first month of admission.[124] Their relatively short length of stay in the workhouse makes it likely that statistics collected on one-day counts may under-represent how many inmates had been admitted with infectious disease associated with a high fatality rate. This would also be the case for the other diarrhoeal disease, cholera.

Asiatic cholera first arrived in England from India in 1831 at Sunderland and spread throughout the country over the next eighteenth months, highlighting the insanitary conditions of industrial Britain.[125] Further epidemics arrived in 1848, 1853 and 1866, although the virulence of the organism varied on each occasion.[126] Bilston was one of the 'worst hit' places during the first epidemic in 1832, with 3,568 cases out of a

[121] BCL, IMC, GP/B/2/4/4/5, 13 January 1908.
[122] BCL, WMC, GP/B/2/3/2/5, 10 January, 5 February 1908.
[123] S. Shave, '"Immediate Death or a Life of Torture Are the Consequences of the System" The Bridgewater Union Scandal and Policy Change' in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse*, Rochester, 2013, 170.
[124] J. Boulton, R. Davenport and L. Schwarz, '"These ANTE-CHAMBERS OF THE GRAVE"? Mortality, Medicine and the Workhouse in Georgian London, 1725-1824' in Reinarz and Schwarz (eds), *Medicine and the Workhouse*, p.77.
[125] R. J. Morris, *Cholera 1832. The Social Response to an Epidemic*, London, 1976, p.17.
[126] Wohl, p.118.

population of 14,500 and a fatality rate of 21%.[127] On the other hand, Birmingham surprisingly escaped with only 31 cases reported.[128] The second outbreak arrived in Wolverhampton Union in August 1848 once again at Bilston Brook, causing 550 deaths in a population of 22,000 within the first month.[129] Like typhoid, it is spread by drinking water or eating contaminated food and can lead to rapid dehydration and death in about half of those affected.[130] The account of John Snow's epidemiological observations of the spread of the disease in Soho during the 1848 and 1853 outbreaks, leading to his 'waterbourne theory', is one of the most familiar in medical history.[131] Although Koch first isolated the bacillus in 1882, it did not gain immediate acceptance as the definitive cause of the disease among British medical opinion.[132] Strict isolation of the sufferers, with careful disposal of their excreta, was the most important preventive measure instituted after the first epidemic.[133] Subsequent improvements in sanitation later in the century and the development of a vaccine in 1893 greatly reduced the impact of the disease.

When 267 cases were recorded in the Wolverhampton Union's districts in one week in August 1849, the guardians considered converting the vagrants' wards as isolation accommodation, but instead bought land to erect a cholera hospital in co-operation with the Committee for Health of Wolverhampton.[134] One woman who tried to escape from the 'contagion raging there' by walking from Bilston to Birmingham was

[127] Smith, p.237; BPP, 1847-48 [921], p1.
[128] Pelling, p.2; BPP, 147-48 [921], p.1.
[129] WALS, *WC*, 3 October 1848.
[130] The infecting organism is the bacillus *Vibrio cholerae*, which causes sudden severe watery diarrhoea, associated with abdominal pain and vomiting.
[131] The debate surrounding the possible cause of cholera are discussed in Pelling, *Cholera, Fever and English Medicine, 1825-1865*, Oxford, 1978.
[132] Worboys, pp. 248, 252; Pelling, p.305.
[133] Smith, pp.232-33.
[134] WALS, WBG, PU/WOL/A/2, 13, 18, 21, 28 August 1849.

admitted to the latter's infirmary with the affliction.[135] By the end of 1849, the epidemic had subsided and the guardians ordered the cholera hospital to be demolished. They agreed a joint plan with the town council in 1853 in anticipation of further outbreaks. The main emphasis was on attempting to keep cholera victims at home rather than admitting them to a cholera hospital, providing houses of refuge for healthy relations and organising dispensaries to give out anti-diarrhoeal medicines.[136]

Before the arrival of Asiatic cholera, the term cholera had been in use, denoting any disease characterised by intense diarrhoea and abdominal pain.[137] Such a disease in infants was known as infantile cholera and in adults, English cholera, both of which were associated with unsanitary domestic conditions.[138] When a case of choleraic diarrhoea occurred in Bilston during the last epidemic in 1866, the MO was able to reassure the guardians that it was the English type.[139] Diarrhoeal diseases formed a substantial proportion of admissions with infectious conditions in the 1850s (Appendix B) and it is not surprising that outbreaks of diarrhoea took place from time to time within workhouses.[140] For instance, several cases of dysentery occurred in Wolverhampton in 1901, requiring the employment of additional nurses.[141] Many Birmingham inmates were affected by an outbreak of diarrhoea in one night in July 1865. Only adults were afflicted: 96 in the old men's wards, 46 in the old women's ward, 24 able-bodied inmates, 2 in the probationary ward, 8 epileptic men and 33

[135] BCL, BBG. GP/B/2/1/6, 11 September 1849.
[136] WALS, WBG, PU/WOL/A/8, 21 September 1853.
[137] W. Bynum, *Science and Practice of Medicine in the Nineteenth Century*, Cambridge, 1994, p.74. No specific organism has been identified with this disease.
[138] Wohl, p.23.
[139] WALS, WBG, PU/WOL/A/13, 14 August 1866.
[140] TNA, MH12/13297-99, 13300.
[141] WALS, WBG, PU/WOL/A/29, 22 November1901. Dysentery is caused by bacilli of the *Shigella* family and results in fever and bloody diarrhoea.

pauper nurses.[142] Edmund Robinson, WMO, put the cause of the outbreak down to miasma from the unsatisfactory drains. However, the clinical pattern of many inmates affected at the same time for a short period, plus patients in the infirmary and children, who would have had a different dietary, being unaffected, suggests the culprit was a mild form of food poisoning. This is the only recorded incident of a major outbreak within either institution, and one presumes that many more must have occurred without being mentioned in the records.

Smallpox

The need for additional facilities for isolation during epidemics meant that cooperation between the responsible authorities was essential. Smallpox was the only one of all the major epidemic diseases that was controlled by means of medical discovery and a successful public health campaign.[143] References to a disease presumed to have been smallpox have been traced as far back as antiquity, but the disease appears to have been more virulent in the early modern period, resulting in several epidemics across Britain in the nineteenth century. It is spread mainly by droplet infection and the disease is contracted in the immediate vicinity of an infected person, even after the death of the sufferer.[144] There is no sign of illness until a week after infection, when symptoms of headache, fever and backache commence, and a rash appears as the fever abates. The patient is infectious from just before the rash until the last scab drops off, as the virus is shed from the rash. The average fatality

[142] BCL, BBG, GP/B/2/1/32, 19 July 1865.
[143] Wohl, p.132; Hardy, p.149.
[144] It is caused by a diminutive, brick-shaped virus, *Variola major*. The rash begins with flat, reddish spots, first on the face, then spreading throughout the body. It becomes raised with blisters, which dry to form crusts or scabs, accompanied with general swelling of the body.

rate is 25%, but many who recover are left with pock-marked facial scarring due to destruction of the sebaceous glands and a few with blindness. The disease confers life-long immunity.[145] A new species of smallpox appeared in the late nineteenth century, producing a milder disease with a fatality rate of only 1%.[146]

Inoculation into the skin of pus or powdered scab to give immunity to the disease had been practised in England from the early eighteenth century, but had a 1% to 3% risk of death.[147] Following the work of Edward Jenner toward the end of the century, vaccination using cowpox or vaccinia virus to produce a mild infection was a safer procedure, but as it did not provide life-long protection, re-vaccination after a few years was necessary. It was commonly performed by vaccinators in the 1860s using the arm-to-arm technique, taking lymph from pustules on a previously inoculated person.[148] These developments in smallpox prevention have been well documented, but, according to Hardy, the nineteenth-century history of smallpox has been neglected by historians.[149]

In susceptible communities, smallpox causes large epidemics, but then declines in prevalence, although can remain endemic in cities. The early nineteenth century witnessed a quiescent period until the epidemic of 1837-40, which resulted in 35,644 deaths in a three-and-a-half-year period in England and Wales, mainly among infants and young children.[150] In Birmingham, 284 deaths from smallpox were registered in

[145] D. R. Hopkins, *Princes and Peasants: Smallpox in History*, Chicago, 1983, p.4.
[146] Known as *Variola minor*.
[147] Hopkins, pp.7, 47; P. Razell, *The Conquest of Smallpox*, Firle, Sussex, 1977, pp.20-21. However, it was less than 1% using the Suttonian method of superficial inoculation, Razzell, pp.22-23.
[148] Worboys, pp. 117-18.
[149] Hardy, p.110; for instance, Razell for eighteenth-century developments.
[150] Creighton, pp.606, 614.

1838, but only 55 the following year.[151] However, there is no mention in the poor law records for Birmingham or Wolverhampton of admissions to the workhouse at this time. The epidemic of 1837-40 brought about the first piece of legislation against smallpox in England, with the Vaccination Act of 1840, which provided free vaccination for children if their parents wished it. A further act, thirteen years later, made it compulsory in infants before they were four months old, financed by the poor law rates under the responsibility of the guardians. In the years following the epidemic, smallpox remained prevalent in the country and isolated cases occurred; for instance, a man with 'virulent smallpox' admitted to Wolverhampton workhouse in 1845 was promptly transferred to a room on his own, under care of a dedicated nurse.[152] Between 1863 and 1865, the number of smallpox patients present in the workhouse at any one time ranged between none and nine, with a peak in May and June of 1864.[153] In November 1863, the workhouse master transferred inmates from isolated cottages to enable them to be used for smallpox patients, as they were the only buildings away from the main hospital.[154] The guardians considered extending facilities for paupers with infectious disease on the grounds that it was better to admit them than to treat them at home in order to increase their chances of recovery, thereby accepting a medical role for the poor law.[155] In May 1864, Birmingham guardians arranged 15 patients on outdoor relief and 10 from the workhouse to be transferred to the General Hospital.[156] However, later that year there were 41 cases of smallpox and

[151] Ibid., p.604.
[152] WALS, MJ, PU/WOL/U/2, 7 June 1845.
[153] WALS, *WC,* 30 September 1863 to 13 September 1865.
[154] Ibid., 18 November 1863.
[155] Ibid., 24 February 1864.
[156] BCL, BBG, GP/B/2/1/31, 25 May 1864.

10 of fever in the institution, which was so crowded that inmates were moved between departments to accommodate the infectious patients.[157]

The next great epidemic took place in 1871-72, resulting in 42,084 deaths in England and Wales in those years and afflicting mostly youths and adults.[158] The increased virulence of the virus resulted in a fatality rate that was much greater, at 66% in the first year and 77% in the second, and also it affected those who had already been vaccinated.[159] According to Hardy, it was the worst of the century.[160] On this occasion, both workhouses in Birmingham and Wolverhampton were deluged by admissions of smallpox sufferers (see Tables 3.2 and 3.3). The guardians in Birmingham found it necessary to appoint a temporary MO, Mr Edward Burton, to care for smallpox patients in the workhouse and prevented him from seeing private patients, unless they had smallpox. Eliza Matthews and Elizabeth Fellon were appointed as additional nurses for patients with smallpox.[161] When the MO commenced duties on 19 December 1871, there were 21 patients in three wards, but, by 10 May the next year, this had increased to 75 patients in seven wards and the time spent treating them had increased from two and a half hours per day to between four and five hours.[162] By the time his services were no longer required on 8 February 1873, he had treated 982 patients.[163]

William Sharp, master of Birmingham workhouse, provided the guardians with a detailed report on the epidemic. The first case to arrive on 11 March 1871 was a

[157] BCL, VGPC, GP/B/2/8/1/4, 2 December 1864.
[158] Creighton, p.614.
[159] Hardy, p.126.
[160] Ibid.
[161] BCL, BBG, GP/B/2/1/40, 27 December 1871, 10 January 1872.
[162] BCL, VGPC, GP/B/2/8/1/6, 10 May 1872.
[163] BCL, BBG, GP/B/2/1/41, 19 March 1873.

servant girl from Hockley, followed on 27 April by four children from London and later by four more. He considered that the disease had not displayed 'much of an epidemic nature' at that time, but the number of admissions increased rapidly after Christmas, for instance 109 admissions in January 1872 compared with 21 in the month before (Table 3.2).[164] The greatest number of patients in the wards at any one

Table 3.2: Number of Patients with Smallpox Admitted, Died and Discharged, Birmingham Workhouse, 1871-74

Year/Month/ Months	Admissions			Deaths			Discharges
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	
1871							
October	3	2	5				
November	11	4	15	2		2	
December	16	10	26	4		4	
1872							
January	68	41	109	10	3	13	
February	37	33	70	5	5	10	
March	53	41	94	7	5	12	
April	70	48	118	12	3	15	
May	64	49	113	10	6	16	
June	62	37	99	9	3	12	
July	44	50	94	8	6	14	
August	32	37	69	3	6	9	
September	15	16	31	6	5	11	
October	33	30	63	7	5	12	
November	20	12	32	4	2	6	
December	14	14	28	3	2	5	
1873							
January	8	8	16	2	2	4	
Total	550	432	982	92	53	145	
Percentage	56%	44%		17%	12%	15%	
January-April 1872			390			56 (14%)	334
January-April 1873			91			12 (13%)	79
January-April 1874			455			66 (15%)	389

Source: BCL, House Sub-committee, GP/B/2/3/3/3, 28 January 1873; Visiting and General Purposes Committee, GP/B/2/8/1/6, 22 May 1874.

[164] The number of admissions in December is different in the written account in the minutes and the table copied into them.

time was 94 on one day in April and two days in June. The Borough sanitary authorities were responsible for arranging 6% of admissions. The mortality rate of 15% was well below the average of 77% for the country as a whole. The patients had been nursed by an inmate under the supervision of the nurse in the female infirmary initially, until the two paid nurses were appointed. Visiting by relatives and friends was strictly prohibited, even when the patient was dying, to ensure complete isolation. The workhouse master praised the conduct of officers and inmates who

Table 3.3: Number of Smallpox cases in Wolverhampton Workhouse and Union District, 1871-72

Date	Workhouse	District	Date	Workhouse	District
1871			**1872**		
27 October		199	1 March	6	74
10 November	9	196	8 March	6	61
17 November	6	209	15 March	5	75
24 November	12	197	22 March	5	59
1 December	12	199	28 March	4	52
8 December	18	215	5 April	3	43
15 December	22	246	12 April	5	42
22 December	20	248	19 April	3	34
29 December	25	225	26 April	3	31
1872			3 May	5	24
5 January	30	220	10 May	6	22
12 January	26	171	17 May	3	15
19 January	18	170	24 May	2	23
26 January	15	135	31 May	6	26
2 February	16	142	7 June	5	27
9 February	8	113	14 June	5	25
16 February	5	100	21 June	6	21
23 February	5	77			

Source: WALS/WBG/PU/WOL/A/14, 27 October 1871 to A/15, 21 June 1872.

were required to attend the patients, as well as that of the patients themselves for 'submitting so readily to the regulations'. Only one man had absconded and another patient had misbehaved. Finally, the concern that the health of the inmates already

present in the workhouse would be endangered proved unfounded as only 12 contracted the disease.[165] Although the number of patients declined after the epidemic, admissions with smallpox continued (Table 3.2). By June 1873, there were only 15 patients in the 103 beds available in the smallpox wards, which were reduced within five months to 30 beds, occupied by 21 patients.[166] However, the reduction in admissions in early 1873 was only a brief respite before a further increase occurred in the early months the following year (Table 3.2).

Smallpox patients were noted to be present in Wolverhampton workhouse at the time the first patients arrived in Birmingham in March 1871, although Henry Gibbons, MO, had declared it free from smallpox one month later.[167] The guardians directed Mr Gibbons to re-vaccinate all inmates who had not been vaccinated within the previous five years.[168] July that year saw five cases occur among inmates in the workhouse, with one death.[169] By October, an increasing number of cases of smallpox was being reported by the district MOs, with a subsequent increase in admissions to the workhouse (Table 3.3). The number of infected paupers peaked around December and January the next year, a few months earlier than in Birmingham. Mary Ann Salt was engaged in November as an additional nurse to care for the smallpox patients for a period of two months.[170] In December, Mr Humphreys, the nurse for the male wards of the infirmary, contracted the infection, but recovered within a few weeks.[171]

[165] BCL, HSC, GP/B/2/3/3/3, 28 January 1873.
[166] BCL, HSC, GP/B/2/3/3, 3 June 1873; GP/B/2/3/4, 25 November 1873.
[167] WALS, WBG, PU/WOL/1/14, 10 March, 14 April 1871.
[168] Ibid., 6 April 1871.
[169] WALS, *WC,* 5 July 1871.
[170] Ibid., 3 November 1871.
[171] WALS, WBG, PU/WOL/1/15, 29 December 1871, 5 January 1872.

The next epidemic in 1884-85 was less severe, resulting in only 5,043 deaths in England and Wales in those years.[172] A case of smallpox was reported to the guardians in Wolverhampton Union's district in the autumn of 1882, when they appointed a temporary attendant for the smallpox wards and stopped workhouse visiting. However, only four patients with smallpox were in the workhouse at that time.[173] When Willenhall Board of Health enquired if they could admit infected patients to the workhouse, they were informed that admission was restricted to paupers.[174] In April the following year, the guardians went further, by forbidding the admission of sufferers of smallpox or 'other infectious epidemic disease' after 8 June. This was successful as the infectious wards were free of smallpox cases by 27 July and the temporary nurse was given notice to leave.[175] Birmingham also experienced an outbreak of smallpox in the workhouse prior to the epidemic in 1884 and all visiting and leave was stopped.[176] Neither institution appears to have admitted smallpox sufferers during the epidemic. By that time, alternative arrangements were in place, in association with the local health boards, for admission for isolation, which was one of the main preventive measures against the disease, along with disinfecting rooms, clothes and bedding.[177]

The vaccination programme in England became less effective after this epidemic as the number of cases decreased, the virulence of the virus declined and the anti-vaccination lobby gained prominence.[178] The fear of catching the disease from vaccination or being infected with syphilis and the risk of scarring in young children

[172] Creighton, p.614.
[173] WALS, WBG, PU/WOL/A/19, 15 September, 3 November, 17 November 1882.
[174] Ibid., 22 September 1882.
[175] Ibid., 27 April, 4 May , 27 July 1883.
[176] BCL, BBG, GP/B/2/1/47, 7 April 1880.
[177] Hardy, p.124; the arrangements in co-operation with health boards is discussed later in the chapter.
[178] Hardy, p.126.

created reluctance to agree to vaccination among the general public.[179] The disease was recognised as highly contagious throughout the nineteenth century, but in the 1870s, opinion became polarised between the anti-contagionists, who believed it resulted from miasma, and the proponents of the new germ theory, who believed a specific infectious agent was the cause.[180] The anti-vaccinationists gained the upper hand and Vaccination Acts of 1898 and 1907 allowed parents to decline protection for their children by stating 'conscientious objection'.[181] Consequently, 33% of unvaccinated children died in the 1893-94 epidemic in Birmingham, compared with only 0.5% of vaccinated children.[182] However, partly due to a decline in virulence of the virus, later epidemics in 1892-93 and 1901-2 were mild.[183]

Isolated incidents occurred in Wolverhampton workhouse in the 1890s and 1900s, unrelated to the times of the epidemics. A man from Willenhall was admitted in February 1893 because of the need for urgent isolation. He had contracted the disease while working in Derby and once back home was sleeping in the same bed as his wife and newborn child. As Willenhall did not have an isolation hospital, the only relevant facilities were in the workhouse.[184] The guardians had contracts with the sanitary authorities in Wolverhampton and Bilston, but not in other districts of the Union. They had been paying Wolverhampton 15s per week for the maintenance of paupers with infectious diseases. However, two years previously, the sanitary authority offered to admit paupers without charge as part of its duty to contain the spread of

[179] Worboys, p. 118; G. Mooney, '"A Tissue of the most Flagrant Anomalies": Smallpox Vaccination and the Centralization of Sanitary Administration in Nineteenth-Century London', *Medical* History, 41 (1991), pp. 261-90, includes detailed discussion of the importance of the objections to vaccination.
[180] Hopkins, p.92 and a discussion of the theories of the cause of smallpox can be found on pp.10-12; Hardy, p.113; Pickstone, p.158.
[181] Hopkins, p.95.
[182] A. Hill, 'The Epidemic of Small-pox in Birmingham', *Public Health*, 8 (1895-96), p.6.
[183] Hardy, p.137; Hopkins, p.96.
[184] WALS, WBG, PU/WOL/A/24, 3 February 1893; *WC*, 8 and 15 February 1893.

infection. After advice from the LGB that the care of such patients was the responsibility of the sanitary authorities, the guardians gave notice to Bilston sanitary authority that they would rescind the contract to pay for paupers admitted to its isolation hospital.[185] When the master reported an outbreak of smallpox in the workhouse in February 1896, Esther Gubby was transferred to the Borough Hospital and Ellen Faulkner, another infected inmate, was transferred the following month.[186] In the winter of 1902-3, two cases of smallpox arrived in the casual wards.[187] The tramp wards were also where an outbreak began in Birmingham in January 1893, at the time of the epidemic. It spread within three months to the infirmary and six months later to the workhouse, as a result of which all visiting was suspended.[188] During the epidemic in 1902, five patients were admitted to the infirmary suspected of having smallpox as they all lived in a lodging house where the disease had been present, but they had been misdiagnosed. However, the next year John Russell was found to have the infection after his admission to the infirmary by the WMO, who claimed there had been no sign of smallpox when examined in the ambulance.[189]

Hardy makes the point that guardians were reluctant to admit smallpox patients into the main workhouse or additional buildings during epidemics.[190] However, the provision of isolation wards and hospitals by the sanitary health authorities was slow to develop and only 20% of authorities had any such facilities by the 1890s.[191] During the 1872 epidemic, Wolverhampton guardians were considering erecting a

[185] WALS, WBG, PU/WOL/A/24, 23 September 1892; *WC*, 28 June 1892, 8 March 1893.
[186] WALS, WBG, PU/WOL/A/25, 7 February 1896, Workhouse Visiting Committee, PU/WOL/H/2, 17 March 1896.
[187] WALS, House Committee, PU/WOL/E/1, 31 December 1902, 15 January 1903.
[188] BCL, WMC, GP/B/2/3/2/1, 13 January 1893; WIMC, GP/B/2/4/4/2, 28 April 1893; WMC, GP/B/2/3/3/2, 27 October 1873.
[189] BCL, WIMC, GP/B/2/4/4/4, 17 February 1902; WMC, GP/B/2/3/2/3, 10 July 1903.
[190] Hardy, p.123.
[191] Wohl, p.138.

new building as a smallpox hospital, but deferred it in preference to using the recently built receiving wards for convalescent smallpox patients and utilising the old receiving wards for their previous purpose.[192] Three months later, the guardians agreed to a request from Wolverhampton Town Council to accept non-pauper patients in the infectious wards of the workhouse on a payment per case basis.[193] Conversely, during the epidemic in the early 1880s, arrangements were made for pauper patients to be admitted to Bilston infectious hospital for payment of 3s per removal, 15s per week and the cost of the funeral. When the LGB questioned this arrangement, the guardians responded that it was the duty of the sanitary authorities to provide isolation facilities in order to keep the workhouse from the danger of a large number of smallpox sufferers in the infirmary wards.[194] Ten years later during the next epidemic, Willenhall Local Board were informed that the isolation wards at the workhouse were not for the admission of out-door paupers.[195]

The arrangements for the isolation of smallpox sufferers in Birmingham involved greater collaboration between the guardians and the Town Council. Admissions of paupers with contagious diseases into the workhouse, including smallpox, only took place after 1864.[196] Because of the threat of cholera around that time, two straw sheds and several stone-breaking sheds at the rear of the workhouse had been converted into wards and they had subsequently been used for smallpox cases. During the 1871 epidemic, they had become overcrowded within ten months of the first admission. In co-operation with the Borough authorities, an additional ward was to be built, but before it was ready, there were more than enough cases to fill it, so a further one was

[192] WALS, WBG, PU/WOL/A/15, 8 January 1872.
[193] Ibid., 5 April 1872.
[194] WALS, WBG, PU/WOL/A/19, 3 August, 7 September 1883.
[195] WALS, WBG, PU/WOL/A/24, 10 February 1893.
[196] BCL, BBG, GP/B/2/1/33, 23 May 1866.

agreed with the same result. The two buildings to hold 30 acute cases were completed and occupied within one week, although several of the workmen contracted smallpox. In addition, two wards for convalescent smallpox patients were erected.[197] The guardians requested payment from Birmingham Corporation for the maintenance of 599 cases sent to the 'smallpox hospital' by the Sanitary Commission between 7 December 1871 and 8 February 1873, an amount totalling £1,388 for 11,101 days at 2s and 6d per day. However, they requested no further cases to be sent.[198]

The following year they agreed to let the buildings containing the smallpox wards to the Town Council, who decided to build additional wards for patients with infectious diseases on land in the workhouse grounds.[199] However, over the next 10 years, there was continual haggling over the length of tenure of the lease and for the majority of the time it remained on annual renewal, despite the guardians agreeing in 1878 that it would be for seven years. In the discussions, the Health Committee requested an extended tenure of the smallpox hospital and declared it would be impossible to find another site for it within Birmingham Borough if the lease was not renewed. The Committee pointed out that the hospital needed 'extensive rebuilding' and that the guardians would also need to provide a separate building for paupers with scarlet fever. As the Committee had purchased a piece of land from the Asylum Committee for the erection of wards for scarlet fever cases, the building in the workhouse grounds would only be for smallpox.[200] The guardians agreed the Corporation could purchase the smallpox buildings and have tenancy of the land as long as it was required. However, they requested that paupers requiring admission should have

[197] BCL, HSC, GP/B/2/3/3/3, 28 January 1873.
[198] BCL, VGPC, GP/B/2/8/1/6, 31 January, 14 February 1873.
[199] BCL, BBG, GP/B/2/1/43, 19 August, 9 December 1874.
[200] BCL, VGPC, GP/B/2/8/1/9, 9 November 1883.

priority over all others.[201] In 1888, the Town Council demolished several of the wooden buildings used for smallpox as they had become 'unfit for human habitation'.[202] However, the epidemic in 1893-94 was more severe in Birmingham than the one in the previous decade and consequently the Town Council had to request the use of the stone yard sheds at the workhouse for treating smallpox cases.[203] Six months later, they were asked to vacate the buildings as soon as possible as the guardians felt that the proximity of the sheds to the workhouse constituted a 'great danger' to the inmates.[204] Anxiety over the danger to the public of isolation hospitals as foci of infection had been growing from the 1870s and protest over the siting of these hospitals was more forceful in London, where every locality voiced opposition to their erection.[205] A challenge by local residents resulted in intermittent closure (1872-75 and 1879-82) of the Metropolitan Asylum Board's first infectious disease hospital in Hampstead and a decision to stop admitting smallpox patients in 1884.[206] When Birmingham Health Committee requested a renewal of the lease for the smallpox hospital in 1896, they indicated that they would no longer use it for smallpox patients, who would be admitted to the Borough Hospital in Lodge Road.[207]

By that time, smallpox prevalence had declined nationally and locally. In Birmingham Registration District, deaths had fallen from 1,042 in the 1870s to 253 in the 1890s, with only one person dying from the disease between 1901 and 1910.[208] The last outbreak of *Variola major* in England occurred in 1901-2, confined mainly to

[201] BCL, VGPG, GP/B/2/8/1/7, 25 July 1878; GP/B/2/8/1/9, 7 December 1884; BBG, GP/B/2/11/52, 19 March 1884.
[202] BCL, WMC, GPB/2/3/2/1, 17 March 1888.
[203] Hill, 'Epidemic of Small-pox', p.5.
[204] BCL, BBG, GP/B/2/1/62, 15 November 1893, 4 April 1894.
[205] M. N. Kerr, 'Sites of complaint and complaining', in J. Reinarz and R. Wynter (eds), *Complaints, Controversies and Grievances in Medicine*, London, 2014, pp.205-6.
[206] Kerr, p.208; Worboys, p.240.
[207] BCL, BBG, GP/B/2/1/64, 1 July 1896.
[208] Woods, p.181.

London, and endemic smallpox disappeared from England in the 1930s. The World Health Organisation declared its eradication worldwide in 1979, the only disease where this has been achieved by immunisation.[209]

Tuberculosis

Mortality from pulmonary tuberculosis (hereafter TB) also declined throughout the nineteenth century, although the reason for this has been a matter of considerable debate. Raised standards of living, better nutrition, sanitary improvements, legislation to control the disease and greater institutionalisation have all been proposed as factors.[210] However, the argument is far from being settled in favour of any one cause.[211] The MO of the LGB in his report for 1905-6 dismissed the proposition of Dr Arthur Newsholme that segregation of tuberculosis patients in workhouse infirmaries had played a dominant role in the decline. He did so on the grounds that TB was not such a highly infectious disease that it would be influenced by isolation, when diseases with greater infectivity had not been controlled in this way. In addition, he felt the average length of stay of TB patients in workhouses was too short to prevent

[209] Hopkins, pp.303, 317.
[210] The arguments are similar to those proposed for the mortality decline as discussed in the introduction to the chapter. TB was used by McKeown and Record to demonstrate their support for higher living standards. For more on TB specifically, see B. Harris, 'Public Health, Nutrition and the Decline of Mortality: The McKeown Thesis Revisited', *Social History of Medicine*, 17 (2004), pp.379-407; L. G. Wilson, 'The Historical Decline of Tuberculosis in Europe and America: Its Causes and Significance, *Journal of the History of Medicine and Allied Sciences*, 45 (1990), pp.366-96; M. Worboys, 'Before McKeown: Explaining the Decline of Tuberculosis in Britain, 1880-1930', in F. Condrau and M. Worboys (eds), *Tuberculosis Then and Now*, Montreal, 2010; G. Cronjé, 'Tuberculosis and Mortality Decline in England and Wales, 1851-1910', in R. Woods and J. Woodward (eds), *Urban Disease and Mortality in Nineteenth-Century England*, London, 1984, pp.79-101.
[211] G. Jones, 'Social History of Medicine Virtual Issue: Tuberculosis', 2013, pp.1-3, accessed 10 May 2013.

spread of the infection; for instance in Birmingham in 1897, it was only 74 days.[212] Newsholme's view gains support from Wilson, who argued that the influence of segregation was sufficient to be the decisive factor. He made the point that by 1905 workhouse infirmaries were being used very extensively for TB patients in England and Wales.[213] Throughout the nineteenth century, there was no change in the medical approach to TB, nor was there any treatment available that could account for the decline.[214] Deaths from pulmonary TB declined steadily throughout the second half of the nineteenth century and the annual death rate in England and Wales decreased by 71% between 1840 and 1905 (Table 3.4). The national rate for other forms of TB also fell, but only by 21% between 1858 and 1900.[215] All types of the disease accounted for 13% of all deaths during the period, but for 33% of those aged between 15 and 34 years, making it primarily a disease of young adulthood.[216] The mortality rate was greater in females until the mid-1860s, when it changed to become more predominant among males.[217] The disease was more prevalent in urban areas, such as Birmingham, where the death rate was higher than the national average and the decrease between 1870 and 1910 was 5% lower than the country as a whole (Tables 3.4 and 3.5). The Black Country also suffered high mortality from TB.[218] It dominated the causes of death among all sections of society and killed more people than any other disease throughout the Victorian era.[219] Despite the mortality decline, TB was the commonest cause of death after heart disease at the end of the nineteenth century.[220]

[212] BPP, 1907 [Cd.3657], pp.240-47.
[213] Wilson, pp.383, 388; this view is supported by Cronjé, p.82.
[214] Cronjé, pp.84-85.
[215] BPP, 1907 [Cd.3657], pp.32-36.
[216] Cronjé, pp.83, 78.
[217] BPP, 1907 [Cd.3657], p.43, facing p.44.
[218] Cronjé, p.97; Woods, 'Sanitary Conditions', p.180.
[219] Cronjé, p.79.
[220] Wohl, p.130.

TB has a long history dating back 20,000 to 35,000 years and evidence of its presence has been found in skeletons in ancient Egypt.[221] Yet, attempts to control the spread of the disease and improve the condition of sufferers did not occur until the late nineteenth century. A major reason why the disease was not seen to be a public health issue in the nineteenth century was the belief that it was an inherited condition arising spontaneously within the body of susceptible individuals, possibly as a result of 'bad living'.[222] Although Koch in 1882 identified a bacterium as the cause of the disease, which he established as contagious, medical opinion in Britain was slow to change.

Table 3.4: Annual Number of Deaths and Annual Death Rates from Phthisis in England and Wales, 1840-1905

Year	Total Deaths	Death Rate per 10,000
1840	59,923	38.9
1850	46,614	26.2
1860	51,024	25.5
1870	54,231	24.1
1880	48,201,	18.6
1890	48,366	16.8
1900	42,987	13.3
1905	38,950	11.4

Source: BPP, 1907 [Cd. 3657], p.36.

Table 3.5: Cause-specific Death Rates for Phthisis, Birmingham Registration District, 1871-1910

Decade	Total Deaths	Death Rate per 10,000
1871-80	5,913	24.8
1881-90	5,232	21.5
1891-1900	4,887	19.9
1901-10	3,036	12.9

Source: Woods, 'Sanitary Conditions', p.180.

[221] T. Dormandy, *The White Death*, London, 1999, pp.1-2; H. Bynum, *Spitting Blood. The History of Tuberculosis*, Oxford, 2012, pp.2, 5.
[222] Bynum, *Spitting Blood,* p.91.

The majority of doctors combined the new bacteriological findings with the old idea of hereditary susceptibility. As the infective nature of TB gained greater acceptance, attempts by MOsH to institute specific preventive measures yielded success by the end of the century.[223]

Tubercles, small nodules in the lungs filled with caseous material, had been identified in the seventeenth century, but it took another 100 years for them to be recognised as pathognomonic of pulmonary TB, known at the time as phthisis by doctors and consumption by the general public. These three terms are similar and will be used to mean the same disease, bearing in mind the difficulties over accurate diagnosis in the nineteenth century.[224] TB is spread by airborne droplets from the sputum of infected humans or in milk from infected cattle. It can affect many organs throughout the body other than the lungs, most commonly the skin, causing lupus vulgaris, and the lymph nodes, known as scrofula. Only about one in ten of those infected develop the pulmonary form, which results in cough, low-grade fever, haemoptysis, night sweats and general wasting, giving it the name of the White Death.[225] It kills 80% of sufferers within five to 15 years.[226]

Treatment in the early nineteenth century was palliative, focussing on the most distressing symptoms of cough, night sweats and diarrhoea. Later, but prior to Koch's discovery of the tubercle bacillus, therapy strove to concentrate the body's ability to overcome the disease through rest, to improve nutrition by a suitable diet and to

[223] Worboys, *Spreading Germs*, p.194.
[224] Koch initially labelled the bacillus he identified in the tubercles as tubercle bacillus, but it is now known as *Mycobacterium tuberculosis*. Infection in humans can also occur from the bacillus that infects cows, namely *Mycobacterium bovis*.
[225] Dobson, p.64.
[226] Dormandy, p.22.

strengthen the lungs by moving to purer atmospheric conditions. Cod liver oil and bathing were also popular remedies. In the 1880s, the inhalation of antiseptics, such as creosote, came into vogue. In 1890, Koch introduced tuberculin, an extract from culture plates of the bacillus, as a specific treatment, but it was soon dismissed as ineffective.[227] Nevertheless, Birmingham guardians acceded to the visiting physician's request to order '50 marks worth' of Dr Koch's lymph from Berlin.[228] Climatic treatment became the gold standard, aiming to place the patient in the environment most likely to limit progression of the disease. It was often combined with exercise to promote full ventilation of the lungs.[229] In the 1880s, this developed into the 'open-air treatment', in which the location became less important than spending as much time outdoors as possible, as outdoor air would contain less bacteria than indoor.[230] The essential factors in open-air treatment were described by a sanatorium physician in 1909 as 'air, rest, feeding and supervision', plus 'time'.[231] Open-air treatment, which was developed in Germany in the 1860s and introduced into Britain in the 1890s, became an established part of the therapeutic regimen in sanatoria.[232] Although isolation of infected individuals was a significant part of their role, they were promoted as providing a cure, through a therapeutic regime of diet, exercise, strict monitoring of temperature and weight, as well as exposure to fresh air, either in huts in the sanatorium grounds or in wards with the windows wide open.[233] Because of the stress on the curative role of sanatoria, admissions were selected to prevent admission of more advanced cases, who frequently ended their lives in poor

[227] Worboys, *Spreading Germs*, p.225.
[228] BCL, WIMC, GP/B/2/3/3/2, 28 November 1890.
[229] Worboys, *Spreading Germs*, p.218.
[230] M. Worboys, 'The Sanatorium Treatment for Consumption in Britain, 1890-1914', in J. V. Pickstone (ed.), *Medical Innovations in Historical Perspective*, New York, 1991, pp.50, 52.
[231] F. W. Burton-Fanning, *The Open-air Treatment of Pulmonary Tuberculosis*, London, 1909, p.83.
[232] Worboys, 'The Sanatorium Treatment', p.47.
[233] Ibid., p.52; Bynum, *Spitting Blood*, p.134; F. Condrau, 'Beyond the Total Institution: Towards a Reinterpretation of the Tuberculosis Sanatorium' in F. Condrau and M. Worboys (eds), *Tuberculosis Then and Now*, Montreal, 2010, pp.80-81.

law infirmaries.[234] Consumptives were also excluded from admission to voluntary hospitals for similar reasons. Specialised facilities were very inadequate, with only 14 sanatoria and 1,000 beds in Britain by 1910.[235] As a result, many poor law infirmaries included sanatorium wards; 12 in London provided open-air treatment and a sanatorium ward was in place in Sheffield around 1904. Purpose-built poor law sanatoria were established in Liverpool in 1902 and Bradford in 1903.[236] Reading Union did not establish dedicated facilities until 1912, providing one ward with four beds for women and one for men with eight beds.[237]

In the early 1850s, the number of patients suffering from consumption in Birmingham workhouse was usually in single figures (Appendix B).[238] When Edward Smith visited on 12 November 1866, there was a designated ward for consumptive cases, containing 19 beds out of a total of 630 in the infirmary.[239] In a national report four years later, there were 26 patients in the infirmary categorised under the 'Phthisis and Tuberculosis' heading, constituting 3.7% of patients under the care of the MO, 1% greater than the national average. However, there were no patients with phthisis or consumption in Wolverhampton workhouse in that year.[240] Around 80 patients with consumption were present in Birmingham when the guardians decided to provide a dedicated ward for open-air treatment, prompted by moves nationally to take measures to manage TB.[241] Dr Short, one of the visiting physicians, cautioned against having all phthisis patients together because of cross-infection between patients.

[234] F. B. Smith, *The Retreat of Tuberculosis*, London, 1998, pp.238-39.
[235] Cronjé, p.82; Worboys, 'Sanatorium Treatment', p.48.
[236] Worboys, 'Sanatorium Treatment', pp.52, 55-56, 216.
[237] Railton and Barr, p.143.
[238] TNA, MH12/13297-99, 13300.
[239] BPP, 1867-68 (4), p.46.
[240] BPP, 1870 (468-I), pp.11, 143, 147.
[241] BCL, WIMC, GP/B/2/4/4/3, 29 July 1901; BBG, GP/B/2/1/71, 3 September 1902.

Many of the patients were, he considered, in Class I in the last stages of the disease. Those in Class II also suffered from bronchitis and because of this were not suitable for open-air treatment. He estimated that there were no more than six cases of those in the early stages (Class III) who had been in the infirmary in the year and only they would benefit. However, he was not in favour of open-air treatment being carried out in the infirmary grounds because of the cold and windy atmosphere to which the patients would be exposed and he cautioned that treatment for less than six months would be useless. Dr Kauffman agreed with him, except that he thought it worthwhile trying it at the infirmary and that Class II would benefit. The third visiting physician concurred with Dr Kauffman, but added that patients would need to agree to undergo treatment for a minimum period of six months. The committee agreed to go ahead with special provision for a few patients, but also to transfer some to a sanatorium. Three sufferers who showed willingness to stay for at least three months were transferred to the Midland Open-Air Sanatorium at Belbroughton at a cost of £1.11.6 each per week, as there was no sanatorium provision in Birmingham at that time.[242] The phthisis hospital in Birmingham infirmary, which cost £444, was operational by the beginning of July 1903, all six beds being occupied by men, each having a separate room.[243] From that date to 26 September the next year, there had been 15 admissions and 10 discharges; details of the five remaining patients are contained in Table 3.6. The ages of nine of those discharged ranged from 19 to 58 years, with a mean of 41. Four were discharged at their own request, three as they had not improved and three described as 'unfit', presumably meaning not suitable for treatment.[244] In the following six months, 18 men were admitted, 14 discharged,

[242] BCL, WIMC, GP/B/2/4/4/4, 17 February, 15 December 1902; IHSC, GP/B/2/4/5/3, 23 December 1902; Dormandy, p.166.
[243] Ibid., 31 August, 6 October 1903.
[244] BCL, IHSC, GP/B/2/4/5/3, 26 September 1904.

leaving four remaining in the ward. Dr Kauffman reported that patients with relatively advanced disease did badly, while those with bronchitis and suspected phthisis were apparently cured. Overall, 'hopeful' cases showed marked retardation of disease after three months, with the greatest improvement in the early period of stay.[245]

The number of admissions of patients with phthisis decreased from 297 in 1904 to 177 in 1905 and 156 in 1906.[246] On 21 May 1906, there were 85 men and 10 women in the infirmary at different stages of the illness. Two women and 14 men were in the early stage, three women and 33 men in the active middle stage and 4 women and 15 men in the active advanced stage. One woman and 23 men had chronic disease and

Table 3.6: Phthisis Patients in the 'Phthisis Hospital' in Birmingham Workhouse on 16 September 1904

Name	Age	Time since admission (weeks)	Progress
W Hexley	49	60	Improved; signs of active decreased
James Bunn	40	59	Slight improvement
Harry Overton	37	34	Improved; signs of active disease modified
Robert Jones	47	36	Some improvement; signs persist but modified
Charles Sampson	45	13	Doing well; signs of disease much diminished

Source: BCL, IHSC, GP/B/2/4/5/3, 26 September 1904.

the MO recommended separate accommodation for them to prevent spread of infection.[247] The reduction in admissions resulted in no patients being transferred to

[245] Ibid., 6 March 1905.
[246] BCL, WIMC, GP/B/2/4/4/5, 25 February 1907.
[247] Ibid., GP/B/2/4/4/4, 21 May 1906.

the phthisis block in the three months to January 1908. Two patients in the block had developed renal inflammation; one had died and the other had been transferred to a ward in the infirmary.[248] As a result, the guardians debated the benefit of continuing with the arrangement. Dr Jordan, who had taken over the care of patients in the block, advanced two reasons why it had not been as successful as expected. First, the quality of the atmosphere was too impure because of many surrounding factories, which also restricted the amount of sunshine.[249] In saying this, he was attributing the therapeutic benefit to the inspired air, a belief supported by Condrau, who asserts that the prime ingredient of institutional therapy was 'fresh air'. However, Worboys disagrees, claiming that it was not pure air that was the therapeutic agent, but the regime in the sanatoria.[250] This accords with Dr Jordan's second reason for failure of the phthisis block, namely the lack of supervision of patients due to its distance from the main building. He added that, on one occasion, one of the medical staff paid a surprise visit to the block and found that the inmates had closed all the windows and doors, which, he claimed, would delay their progress by two months.[251] The inmates' actions support Condrau's assertions that patients are not merely objects of institutional therapy and that an institution exists independently of its inmates.[252] Dr Jordan suspected that TB sufferers would not present for admission to the infirmary at an early enough stage of the disease to be suitable for open-air therapy as they would prefer to continue working as long as possible and he concluded that patients would gain more benefit in dedicated wards within the infirmary. The decision was taken to

[248] Ibid., GP/B/2/4/4/5, 27 January 1908.
[249] Ibid., 9 March 1908.
[250] Condrau, pp.80-81; Worboys, 'Sanatorium Treatment', p.52.
[251] BCL, WIMC, GP/B/2/4/4/5, 9 March 1908.
[252] Condrau, p.80.

close the block accordingly, no doubt aided by the fact that the efficacy of sanatorium treatment was beginning to be questioned at that time.[253]

The WMO at Wolverhampton also practised open-air treatment. Early in the twentieth century, the guardians requested the architect to determine how the buildings proposed for the new workhouse could be adapted to provide 'outdoor treatment of phthisical cases'.[254] However, no dedicated facilities are included in the plan of the hospital dated 1902.[255] After the new workhouse had been operational for one year, the MO suggested conversion of a window into a doorway in the surgical ward, which contained patients suffering from TB of bones in the leg and spine. This would prevent them from being carried out through a corridor and airing court and give direct access to the outside of the ward. He stressed that open-air treatment was necessary for these patients.[256] It took the guardians almost two years to seek the approval by the LGB for the alteration, and a further year for the LGB inspector to visit to give his approval.[257] Three years later, the guardians agreed to widen a door so that patients could be moved out of the ward in their beds.[258] In the meantime, the guardians approved the purchase of six coats to enable phthisical men to get out in the open-air as much as possible.[259] They were also concerned regarding phthisical patients 'expectorating on the floors' because of the danger to other patients and threatened any doing so with prosecution for disobeying rules.[260] Birmingham

[253] BCL, WIMC, GP/B/2/4/4/5, 9 March 1908.
[254] WALS, New Workhouse Committee, PU/WOL/S/1, 27 November 1901.
[255] WALS, Block Plan, Wolverhampton Union Workhouse, DX/120/10/10, 1902.
[256] WALS, HC, PU/WOL/E/2, 15 December 1904.
[257] Ibid., 20 September 1906, 31 October 1907; PU/WOL/E/3, 9 June 1910.
[258] WALS, HC, PU/WOL/E/3, 9 June 1910.
[259] WALS, HC, PU/WOL/E/1, 11 February 1904.
[260] WALS, Special Committees, PU/WOL/P/1, 25 January 1906.

guardians also considered the provision of 'receptacles for the spittle of phthisis patients' and the best way of disposing of it safely.[261]

In the year ending Michaelmas 1908, there had been 346 admissions due to TB into Birmingham infirmary, with 69 admitted more than once. Of the 277 patients admitted, 201 were men, 62 women, 5 boys under 15 years of age and 3 girls of similar age. Only six women were admitted for a second time, but of 40 men who took their own discharge, as they wished to resume work to provide for their families, 25 were admitted for a second time, 9 for a third time, 5 for a fourth time and one had six admissions.[262] Over the next few years, the number of admissions remained constant, except for the third quarter of 1911, and the number of phthisis patients present in the infirmary (Table 3.7) was similar to that at the turn of the century at 80 and in 1906 at 85 men and 10 women.[263] The high mortality rate reflects the severity of the disease in patients admitted who were frequently in the terminal stages, but compares favourably with an estimated mortality rate of around 20% at the City of London Hospital for Chest Diseases in the 1880s.[264] When Edinburgh City Hospital opened in 1906, the death rate of the first 104 admissions was as high as 46% because many of the patients were in the later stages of the disease. Of the 48 who died, 11 did so within 10 days of admission.[265]

Phthisis was responsible for the largest number of deaths in Birmingham infirmary in the years 1905 to 1908 inclusive, causing 16% of the 1,707 who died.[266] It was the

[261] BCL, WIMC, GP/B/2/4/4/5, 10 January 1910.
[262] Ibid., 11 January 1909.
[263] BCL, WIMC, GP/B/2/4/4/2, 29 July 1901; GP/B/2/4/4/4, 21 May 1906.
[264] Dormandy, pp.83-84.
[265] Gray, p.171.
[266] BCL, WIMC, GP/B/2/4/4/5, 14 December 1908.

commonest reason for admission in the year ending 31 May 1910, affecting 246 patients and accounting for 7% of the 3,338 admitted.[267] This is in stark contrast to Smith's estimate, based on extrapolating data from Liverpool, that 60% of admissions to workhouse infirmaries in England and Wales were of consumptive patients.[268]

Table 3.7: TB Patients in Birmingham Infirmary for Specific Time Periods, 1909-11

Time Period	Present on first day of period	Admitted	Discharged	Transferred to Workhouse	Died	Mortality Rate
1st quarter of 1909	73	64	35	2	20	15%
2nd quarter of 1909	80	67	53		35	24%
1st quarter of 1910	72	78	32		37	25%
2nd quarter of 1910	81	66	45		35	24%
1st quarter of 1911	74	80	64		31	20%
2nd quarter of 1911	79	80	79		25	16%
3rd quarter of 1911	55	118	70		29	17%
Year: 1909	73	333	197		119	29%
Year: 1910	72	282	128	12	140	40%

Source: BCL, WIMC, GP/B/2/4/4/5-6, 1909-11.

An alternative to open-air treatment that became popular in Britain in the early twentieth century was a model of occupational therapy or graduated labour. It was pioneered by Marcus Paterson, medical superintendent at the Brompton Hospital Sanatorium at Frimley in Surrey. Patients started with walking and after they were able to do ten miles, carried baskets, which gradually were made heavier, and finally they progressed to digging.[269] Paterson claimed that it prepared patients for an immediate return to work on discharge. This was one of the reasons given by Thomas

[267] Ibid., 11 July 1910.
[268] Smith, p.105.
[269] Bynum, *Spitting Blood*, p.142; Condrau, pp.74-75.

Galbraith, WMO at Wolverhampton, for implementing a similar scheme of graduated exercise for men. They started with walking for half-a-mile daily after their temperature had returned to normal on bed rest. After they could manage six miles daily, graduated labour was begun. This consisted of very light work, such as carrying a basket, weeding, potting, watering plants, and was increased to heavier carrying, planting out, cutting vegetables after about one week. Further stages included sweeping paths, cutting edges, hoeing; then light digging, mowing grass; and finally digging, trenching, sawing, until fit to resume their previous occupations. Galbraith estimated this would take 14 to 17 weeks and that 15 male patients in the workhouse would benefit from the scheme. Its other advantage would be overcoming the demoralising effects of long periods of mental and physical inactivity. The guardians agreed to proceed and delegated the newly appointed male charge nurse to provide close supervision of the men who would be taking part.[270] They decided not to erect dedicated buildings for the men to sleep at night, but chose to add balconies to the existing wards. Once again, they made alterations to the doorway in the male surgical ward to enable patients to be taken out into the open air in their beds.[271] Galbraith did not think that there were a sufficient number of female patients to justify instituting the same arrangements. It was agreed that the ward in which they resided should be portioned so that their part could be provided with as much ventilation as possible.[272] Strict adherence to the exercise programme was considered necessary for success. The MO in Reading Union workhouse found it difficult to persuade patients to remain for the full course of treatment, as the regulations for phthisical patients were so detailed and so tedious. However, patients were notified that the programme would be of 'no use to them', if they did not 'co-operate heartily… in every detail of

[270] WALS, HC, PU/WOL/E/4, 27 August 1913.
[271] Ibid., 31 July 1913.
[272] Ibid., 22 August 1913; WOL/PU/E/5, 17 April 1914.

the routine' by 'cheerfully acquiescing in every direction given to them'.[273] They were also informed that the average length of stay was three months, which was similar to the time that tuberculous patients were required to commit to treatment in Birmingham infirmary.[274]

Summary

It has been claimed that workhouses were efficient at preventing admission of paupers with infectious diseases, but this conclusion was based on mortality data.[275] This chapter has demonstrated that the contribution of workhouse infirmaries in Birmingham and Wolverhampton to the care of children with infectious disease, to patients with endemic diseases such as typhus and typhoid and to victims from the cholera epidemics was substantial. Their role in isolating patients with infectious conditions assisted greatly in preventing the spread of infection within their communities. The guardians' attempts in mid-century to prevent admission or seek alternative institutions for paupers were based mainly on the concern that infection introduced into the workhouse might affect the incumbent inmates. Workhouses had a reputation as 'contagious spaces', but whether spread of infection within them due to overcrowding and unhygienic conditions took place is, according to Ruth Hodgkinson, 'a moot point', but she gave one example of a serious outbreak of

[273] Railton and Barr, pp.143-44.
[274] Ibid., p.144; BCL, IHSC, GP/B/2/4/5/3, 23 December 1902.
[275] G. Mooney, B. Luckin and A. Tanner, 'Patient Pathways: Solving the Problem of Institutional Mortality in London during the later Nineteenth Century', *Social History of Medicine*, 12 (1999), p.244.

cholera in Leeds workhouse in 1834, at a time where there were few cases in the town.[276]

Poor law facilities were used extensively in Birmingham to cope with smallpox epidemics, as happened in Wolverhampton to a lesser extent and mostly during the epidemic of the 1870s. In both towns, access by non-pauper patients to workhouse accommodation was permitted. Until the end of the nineteenth century, institutional provision for smallpox patients in Birmingham was in poor law buildings and on workhouse land, leased by guardians to the corporation. It was not unusual for workhouse infirmaries to be utilised in this way. Although the Public Health Acts of 1866 and 1875 empowered sanitary authorities to build hospitals and permitted compulsory isolation of patients, the development of isolation hospitals by local authorities was slow until the 1890s, although the smallpox epidemics gave a degree of impetus.[277] Fever hospitals that existed were small, usually containing around 70 beds, until the 1880s.[278] John Pickstone notes that arrangements for fever in the Manchester region other than provided by guardians were present only in Manchester, Preston and Lancaster in the 1860s.[279] Until the 1890s, it was still possible for smallpox patients to be admitted to general workhouse wards.[280] Both Birmingham and the borough of Wolverhampton had an isolation hospital by 1892, the one in the latter town accommodating around 36 patients. It had only been available for one year, although some beds had been available for the previous ten years. However, the

[276] K Siena, 'Contagion, Exclusion and the Unique Medical World of the Eighteenth-Century Workhouse', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse*, Rochester, 2013, p.28; R. G. Hodgkinson, *The Origins of the National Health Service*: *the Medical Services of the New Poor Law 1834-71*, London, 1967, p.161.
[277] Pickstone, pp.156, 158; Wohl, p.138; Currie, pp.13, 125-26.
[278] Smith, p.241.
[279] Pickstone, p.160.
[280] Smith, p.389.

lack of isolation facilities in all districts making up Wolverhampton union meant that poor law accommodation continued to be utilised. Furthermore, the question of who should pay for paupers admitted to isolation hospitals within the union created conflict between guardians and sanitary authorities. Satisfactory arrangements were not in place in Wolverhampton as late as 1912. When Annie Birch was admitted to the infectious diseases hospital, the guardians accepted liability for the charges, but warned that, in future, they would only do so if they had requested the admission.[281] In Birmingham, the new infectious hospital had 300 beds, but buildings, which were still being leased from the guardians, could accommodate a further 100 patients. While there had been no cases of smallpox in the Wolverhampton hospital from 1888 to 1892, 89 patients had been treated in Birmingham; for scarlet fever, the numbers treated were 1,217 and 7,206 respectively.[282] The extent of co-operation between the poor law and sanitary authorities in Birmingham, with joint management of facilities for infectious disease, was exceptional.

Although it has been acknowledged that poor law infirmaries provided the larger share of accommodation for patients with TB, they have not been given credit for instituting current methods of treatment. Both Birmingham and Wolverhampton guardians began taking steps to provide dedicated accommodation and access to fresh air for patients early in the twentieth century, whereas many urban workhouses had not done so by the end of that decade.[283] Following this, they adopted the regime carried out in sanatoria, which has been described as being 'the bedrock of treatment' for nearly one hundred years.[284] That it did not succeed in Birmingham may have

[281] WALS, HC, WOL/PU/E/4, 18 January 1912.
[282] BPP, 1895 (28), pp.352-55, 400-3.
[283] BPP, 1909 [Cd. 4573], p.92.
[284] Dormandy, p.148.

been because the environmental conditions were not conducive. Within the historiography of TB, the poor law sanatorium set up at Heswall at the start of the twentieth century gets a brief mention.[285] The intention was to provide treatment for those at an early stage to return them to employment. However, it had the disadvantage that all patients had to be admitted via the workhouse. As happened in Birmingham, patients were reluctant to enter the workhouse until in the later, non-ambulant stages and Heswall became 'a staging post of the dying'.[286] Perhaps it was because poor law infirmaries were seen to cater mainly for TB patients who were terminal, that they have received so little attention from historians. The initiative in instigating current methods of treatment for TB patients was taken by the MOs in both workhouses and their part in providing general care for sick inmates will be considered in the next chapter.

[285] Ibid., pp.166-67; Smith, pp.104-5.
[286] Dormandy, p.167.

CHAPTER 4

WORKING CONDITIONS OF THE MEDICAL OFFICERS

'my unremitting duties'…'[have] become so great as at times completely exhaust me'.[1]

Under the Old Poor Law, parishes paid for medical attendance on a fee for service basis, but by the early nineteenth century, many found it more convenient to contract with a medical practitioner based on an annual salary.[2] After the Poor Law Amendment Act (1834), the Poor Law Commissioners (hereafter PLCs) authorised boards of guardians to appoint medical officers (hereafter MOs) for the provision of outdoor medical relief and for the attendance on sick inmates in workhouses. From this directive, there developed a new branch of the medical profession, poor law MOs.[3] In shaping this new kind of practitioner, with a broader interest in social

[1] Birmingham Central Library (hereafter BCL), Birmingham Board of Guardians (hereafter BBG), GP/B/2/1/15, 28 February 1855; GP/B/2/1/19, 8 April 1857.
[2] E. G. Thomas, 'The Old Poor Law and Medicine', *Medical History*, 24 (1980), p.7; A. Crowther 'Health Care and Poor Relief in Provincial England' in O. P. Grell, A. Cunningham and R. Jütte (eds), *Health Care and Poor Relief in 18th and 19th Century Northern Europe*, Aldershot, 2002, p.209.
[3] The major narratives concerning poor law medical officers are R. G. Hodgkinson, *The Origins of the National Health Service: the Medical Services of the New Poor Law 1834-71*, London, 1967; M. W. Flinn, 'Medical Services under the New Poor Law', in D. Fraser (ed.), *The New Poor Law in the Nineteenth Century*, London, 1976; J. L. Brand , *Doctors and the State*: *The British Medical Profession and Government Action in Public Health, 1870-1912*, Baltimore, 1965; R. G. Hodgkinson, 'Poor Law Medical Officers of England, 1834-1871', *Journal of History of Medicine and Allied Sciences*, XI (1956), pp. 299-338; J. L. Brand , 'The Parish Doctor: England's Poor Law Medical Officers and Medical Reform, 1870-1900', *Bulletin of the History of Medicine*, 35 (1961), pp.97-122; M. A. Crowther, 'Paupers or Patients? Obstacles to Professionalisation in the Poor Law Medical Service Before 1914', *Journal of the History of Medicine*, pp. 39 (1984), 33-54; A. Negrine, 'Medicine and Poverty: A Study of the Poor Law Medical Services of the Leicester Union 1876-1914' (unpublished PhD thesis, University of Leicester, 2008). These officers are also included in the discussion of poor law medical services in E. Bosworth, 'Public Healthcare in Nottingham 1750-1911' (unpublished PhD thesis, University of Nottingham, 1998); J. Reinarz and A. Ritch, 'Exploring Medical Care in the Nineteenth-century Provincial Workhouse: a view from Birmingham', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse*, Rochester, 2013; A. Negrine 'Practitioners and Paupers', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse*, Rochester, 2013.

medicine, the Act changed the relationship between the poor and the doctor, who no longer thought of himself as a local contractor.[4] Nevertheless, guardians treated MOs on the same basis as other officers or servants employed by them. For instance, William Sturrock, workhouse medical officer (hereafter WMO) in Birmingham, complained in 1900 that he was allowed only three weeks' annual leave, whereas other first-class officers had four. He claimed, this 'seems like a slur on Medicine that its representative should be ranked with subordinate officers'.[5] However, the terms of employment of MOs differed in that the majority had part-time contracts and continued with private practice. Immediately after the New Poor Law (hereafter NPL), guardians appointed the doctor offering the lowest tender. This arrangement was abolished after the General Medical Order of 1847 required a salary decided by the guardians to be stated at the time the post was advertised. MOs were usually appointed on an annual basis, although the Order had directed that tenure should be permanent. It also required them to be qualified as surgeons and apothecaries.[6] This was modified by an Order in 1859 to require qualifications to practise medicine and surgery in England and Wales, thereby ensuring that poor law MOs were better qualified than practitioners in private practice. However, the dual requirement could be circumvented if MOs lived outside the district of their responsibility. Although salaries were set by guardians prior to appointment, they remained very low, varied greatly and were a cause of frequent complaint.[7] MO posts were accepted out of necessity in a highly competitive medical market, even though the positions were despised.[8] They were usually taken by young practitioners setting out in practice or

[4] M. Brown, *Performing Medicine*, Manchester, 2011, p.173.
[5] BCL, House Sub Committee (hereafter HSC), GP/B/2/3/3/20, 24 July 1900.
[6] Hodgkinson, 'Poor Law Medical Officers', pp.301, 306.
[7] Ibid., p.302; Brand, 'Parish Doctor', p.100.
[8] C. Lawrence, *Medicine in the Making of Modern Britain, 1700-1920*, London, 1994, pp.42-43.

those who failed to acquire sufficient income from private practice.[9] They were seen as third-rate practitioners, who had failed to succeed in private practice, because they were poorly paid, worked for a state service, which did not attract ambitious doctors, and were subservient to public officials in the form of the boards of guardians.[10] The patients they treated suffered from diseases that were considered uninteresting and from the stigma of pauperism. Their places of work, the workhouse infirmaries, were less prestigious than the voluntary hospitals. Their status reflected the level of their remuneration and the class of their patients and their professional position remained unsatisfactory throughout the nineteenth century.[11] Despite this, they were the one common denominator within a patchwork of welfare practices and fundamental to medical welfare.[12]

This chapter will consider the conditions under which the MOs of Birmingham and Wolverhampton laboured and will provide an estimate of their workload. The questions it attempts to answer include to what extent the NPL influenced the institutional medical care of paupers and how did the development of infirmaries affect medical staffing? A comparison between the arrangements in Birmingham and Wolverhampton has allowed exploration of possible differences in the performance of resident and non-resident MOs. For instance, was the greater continuity of medical care that occurred with the appointment of non-resident staff a positive advantage? How they came into conflict with guardians and other poor law officers over patient care and why MOs were at times exonerated, but at others were charged with medical

[9] I. Loudon, *Medical Care and the General Practitioner 1750-1850*, Oxford, 1986, p.228.
[10] Crowther, 'Paupers or Patients?', p.40.
[11] Loudon, *Medical Care*, p.227; Flinn, p.54.
[12] K. Price, 'A regional, quantitative and qualitative study of the employment, disciplining and discharging of workhouse medical officers of the New Poor Law throughout nineteenth-century England and Wales' (unpublished PhD thesis, Oxford Brookes University, 2008), p.335.

negligence, will be explored. To what extent did the imposition of charges reflect the approach of MOs to their patients? The chapter will commence with details of the MOs, followed by an analysis of their conditions of employment and the number of patients they cared for. It will question whether the MOs' workload compromised their management of patients.

Appointment and Duties of the Workhouse Medical Officer

The duties of the WMO were prescribed in Article 78 of workhouse regulations in the Second Annual Report of the PLCs in 1836. These required him to attend at times stated by the guardians and in emergency at the request of the master; to visit the sick as their condition necessitated; to examine all lunatics; to give directions for inmates' diets; to provide and dispense all medicines; to keep a register of morbidity and mortality; and to provide the guardians with regular reports on the inmates treated. He was required to inform the guardians of defects in sanitation, ventilation and heating and the conduct of the nursing staff. All admissions to the workhouse were to be examined by him and classified into the appropriate group. In particular, he had the task of separating the 'able-bodied', who could be assigned work, from the 'non-able-bodied'. This and his duty to decide the fitness of inmates for punishment meant that he was seen as much a part of the disciplinary system as the provider of medical care.[13] In 1847, the task of vaccinating all children entering the workhouse was added to his list of duties.[14] According to Kim Price, his workload must have been 'immense', making it almost impossible for him to carry out his duties

[13] Crowther, 'Paupers or Patients?', pp.47-49.
[14] For further information on the management of smallpox, see chapter 3.

conscientiously.[15] As he was able to appoint an assistant, without medical qualifications, it was often left to that individual to attend to those in the workhouse, while the MO devoted his time to his private patients.[16] This was possible as the most usual arrangement for medical care for inmates of the workhouse was for guardians to engage a private practitioner, whose contract may have included duties as a district medical officer (hereafter DMO) in addition. Jeanne Brand is of the opinion that the regulations relating to MOs were so general that they allowed not only considerable variation in performance, but 'outright abuse'.[17]

Less frequent practice was the appointment of a whole-time MO specifically for the workhouse, sometimes with the requirement to reside within it. Full-time employment within workhouses was a controversial issue, opposed by *The Lancet* and Dr Edward Smith, MO to the Poor Law Board (hereafter PLB).[18] Joseph Rogers, a reformer and WMO in the 1860s, was instrumental in getting the requirement for the infirmaries in London to have resident MOs supervised by visiting physicians included in the Metropolitan Poor Act of 1867.[19] Over the following four years, the number of WMOs who were resident in the capital increased from three out of a total of 12 to seven of 13.[20] By the early 1880s, a majority of metropolitan MOs served full-time and no longer carried out private practice.[21] In the provinces, they were most likely to be appointed in large urban workhouses, such as Liverpool,

[15] Price, 'Quantitative and qualitative study', p.154.
[16] Ibid, p.21; M. A. Crowther, *The Workhouse System, 1834-1929*, London, 1981, p.163.
[17] Brand, 'Parish Doctor', p.105.
[18] A detailed discussion of the two sides of the argument appears in Hodgkinson, 'Poor Law Medical Officers', pp.317-19.
[19] Rogers T. (ed.), *Joseph Rogers, MD, Reminiscences of the Workhouse Medical Officer*, London, 1889, pp.xviii-xix, 60-61.
[20] Hodgkinson, *Origins of NHS*, pp.399-401.
[21] Brand, 'Parish Doctor', p.110.

Table 4.1: Resident Workhouse Medical Officers in Birmingham Workhouse, 1830-1914

Name	Time in office	Annual salary	Reason for termination
Joseph Pedley	March 1830 - March 1837	£50-£70	Died
A. H. Nourse	March 1837 - July 1839	£70	Resigned; private practice
Charles Smith	July 1839 - March 1850	£70	Reorganisation of medical officers
John Humphrey	March 1850 - April 1855	£150-£175	Appointed to civil hospital
William Fernie	May 1855 - April 1857	£150	Resigned
John Wilmshurst	May 1857 - May 1858	£150	Resigned
John Redfern Davies	June 1858 - October 1861	£150-£200	Resigned at request of guardians
Edmund Robinson	October 1861 - January 1869	£200-£350	Appointed public vaccinator
Edmund Whitcombe	February 1869 - July 1870	£200	Appointed to Borough Lunatic Asylum
Adam Simpson	August 1870 - August 1886	£200-£350	Removed from office by LGB
Charles Mitchell	August 1886 - January 1890	£207	Resigned
Edmund Corder	February 1890 - February 1890	£150-£200	Resigned
Ebenezer Teichelmann	February 1890 - September 1891	£150-£200	Resigned
George Ferraby	October 1891 - October 1894	£150	Appointed DMO
George Barber	November 1894 - May 1895	£150	Resigned
Alexander McDougall	May 1895 - March 1899	£150-£200	Appointed DMO
William Sturrock	May 1899 - September 1914	£150-£200	Leave to take up active service

Source: BCL, BBG, GP/B/2/1/3-67, March 1830 to September 1899; Advisory Sub Committee, GP/B/2/8/2/1, 23 September 1914.

Nottingham, Manchester and Birmingham (see Table 4.1).[22] Although whole-time contracts became more usual from the 1870s, 93% of the 625 unions in England and Wales still had no resident MO in 1900. Birmingham was unusual in appointing a resident MO to the workhouse as early as 1823, but was not unique for a provincial workhouse as Nottingham had one from 1822.[23]

[22] Hodgkinson, 'Poor Law Medical Officers', pp.319-20; BCL, LGB Returns, GP/B/18/2/1, 15 October 1856.

Legacy of the Old Poor Law

After 1834, there was a marked reduction in the number of MOs' posts in the new unions. In seven examples given by Irvine Loudon, the extent of the removal of medical men ranged from 50% to 81%.[24] Birmingham, at the time of the NPL, employed six surgeons who received £30 *per annum*, were each allocated to a district, with responsibility for attending patients in their homes and at the town dispensary. They all had duties in the Town Infirmary, where the medical staffing also consisted of one resident house surgeon (hereafter HS) and apothecary, plus two assistant apothecaries. The HS was paid an annual salary of £70 and received free accommodation and board (Table 4.1). His duties, prescribed prior to the NPL, included visiting each ward twice daily and providing a list of necessary drugs, plus responsibility for cleanliness and 'good order' of the sick wards and 'superintendence' of the nurses.[25] The assistants were non-resident and had an annual salary of £50; their duties were not stated, but would have included dispensing drugs. The inpatient workload of all the MOs in the three months of April to June 1834 consisted of between 116 and 123 patients, while that for the surgeons also included 2,722 seen in the dispensary, 1,385 seen at home and 108 midwifery cases to monitor in association with the poor law midwives.[26] By comparison, the MO of Nottingham Union in July 1837 was responsible for 58 patients in the union hospital, 47 in the workhouse and 351 outpatients, with the help only of a dispenser in the institutions.[27] One of the Birmingham surgeons was Edward Cox, whose son, Sands Cox, assisted

[23] BCL, BBG, GP/B/2/1/1, 11 March 1823; Bosworth, p.206.
[24] Loudon, *Medical Care*, p.238; the unions were Derby, Lincoln, Bridgewater, Aylesbury, Eton, Shipston and Newbury.
[25] BCL, BBG, GP/B/2/1/3, 3 June 1827.
[26] BCL, BBG, GP/B/2/1/3, 8 July 1834.
[27] Bosworth, pp.210-11.

him in the workhouse and later became honorary surgeon to the Queen's Hospital, of which he was a founder.[28] Ten years later, it was decided to separate the indoor and outdoor medical relief, as the HS was being 'called out of the workhouse' frequently, and six further surgeons were appointed for district work only. It was planned to reduce the existing surgeons (who were to work in the infirmary only) to four as vacancies arose, with a reduced salary of £10 *per annum*.[29] At that time, the number of patients in the infirmary had increased to around 150, while that of dispensary patients had fallen by half.[30] The following year, one of the surgeons, Thomas Green, took on the sole responsibility for the lunatic wards.[31] Rather than a reduction, more surgeons were appointed, so that by March 1847 sixteen were in post, with annual salaries of between £10 and £20, except for Green who received £55.[32]

As Birmingham Parish had been established by an individual act of parliament, the guardians could resist aligning with the regulations of the NPL for many years. However, the increasing influence of the central authority, exerted through the PLB inspectors, resulted in a radical reorganisation of medical staffing in 1849, with a substantial reduction in the number of MOs. The number of sick in the infirmary (160) had not shown an increase in recent years, but the new workhouse was in the planning stage with a proposed infirmary of just over 300 beds.[33] Inpatients were to be cared for by only one resident HS at an enhanced annual salary of £150, plus

[28] Sands Cox also founded Queen's College, which developed into the medical school and ultimately the University of Birmingham.
[29] BCL, BBG, GP/B/2/1/4, 2 July, 18 December 1844.
[30] Ibid., 8 October 1844.
[31] BCL, BBG, GP/B/2/1/5, 22 July 1845. Thomas Green was appointed the first house surgeon to the infirmary in 1823, a post he held for three years, became one of the visiting surgeons in 1831, and was appointed superintendent at the Borough Asylum in 1850.
[32] Ibid., 15 March 1847.
[33] Ibid., 21 February 1848.

'lodgings, coals and candles'.[34] His duties would be governed by the workhouse regulations laid down by the PLB, and the guardians would continue to cover the cost of drugs. The salary may have been improved in the hope of obtaining a more experienced practitioner or it may have reflected the anticipated increase in workload. The surgeons were reduced to six, with responsibility for only outdoor medical relief, at an annual salary of £150, which was to include the cost of all 'drugs, medicines and surgical appliances'.[35] Notice was given to the assistant apothecaries and surgeons that their services would not be required after Lady Day in 1850.[36] Charles Smith, HS, did not apply for the redesigned post, although the fact that he was then aged 66 years may have influenced his decision. Fifteen candidates applied and John Humphrey was elected. Five of the pre-existing surgeons were appointed to the six new DMO posts, out of a total of 46 applications.[37] The WMO was no longer supported by more senior colleagues, although the guardians allowed him to request a second medical opinion from physicians and surgeons in the town, who were paid a fee for their services. Despite the increasing medical role of Birmingham infirmary, the PLB had succeeded in reducing medical staffing and thereby the quality of patient care.

Meeting an Increasing Workload after the New Poor Law

John Humphrey transferred to the new workhouse when it opened in March 1852. Between then and 1914, 14 MOs held the office of resident surgeon, serving for

[34] BCL, BBG, GP/B/2/1/6, 27 June 1849.
[35] Ibid.
[36] Ibid., 11 December 1849.
[37] BCL, BBG, GP/B/2/1/7, 15 March 1850.

periods varying from one month to sixteen years with an average just over four and a half years (Table 4.1). With only four MOs spending more than five years in office, there was little continuity of medical care, which varied according to the practices of individual officers.[38] This is similar to the situation at the town's General Hospital where the resident MOs between 1857 and 1875 had an average length of service of approximately three years. However, continuity was provided by eight honorary physicians and surgeons, whose periods in office ranged from eight to 37 years.[39] A similar situation was not initiated at the workhouse until 1882, when a visiting physician was appointed, followed by a visiting surgeon five years later. The stimulus for these appointments was a visit, at the request of the guardians, by two Local Government Board (hereafter LGB) inspectors, one of which was Dr Frederic Mouat M.D. They suggested that two non-resident MOs should be appointed to provide adequate medical cover.[40] The guardians' reaction was to send a deputation to assess the medical administration of the workhouse at Liverpool, which housed around 3,000 inmates, compared with about 2,500 in Birmingham. Both the medical and surgical officers in Liverpool were non-resident, visited the workhouse daily and supervised the three assistants. The Liverpool guardians allowed the non-resident officers to have private practices in order to attract high quality candidates.[41] Birmingham guardians decided to appoint only one visiting physician, Dr Cornelius Suckling, who already held an appointment as honorary physician to the Queen's Hospital and became Professor of Medicine at Mason's College, the precursor to the University of Birmingham.[42] Five years later, Dr George Jordan Lloyd was appointed

[38] BCL, BBG, GP/B/2/1/6-68, January 1850 to December 1899.
[39] BCL, General Hospital, Birmingham, Annual Reports, 1857-75.
[40] BCL, Visiting and General Purposes Committee (hereafter VGPC), GP/B/2/8/1/8, 21 March 1882.
[41] BCL, HSC, GP/B/2/3/3/8, 4 July 1882.
[42] G. Hearn, *Dudley Road Hospital*, *1887-1987*, Birmingham, 1987, p.23.

visiting surgeon at the workhouse at the same annual salary of £150.[43] At the time of his appointment to the workhouse, Lloyd was Honorary Surgeon to the Queen's Hospital and later became Professor of Surgery in the University of Birmingham. In making these appointments, the guardians were emulating the staffing arrangements at the voluntary hospitals. The WMOs continued to be appointed to full-time duties, were required to be resident and were not permitted to practice privately. Starting salaries rose from £150 per annum plus board, lodgings and a personal servant, to £200 per annum in 1861, but returned to the previous level in 1890 after the new infirmary opened (see Table 4.1).[44]

WMOs during these decades resigned for a variety of reasons. For example, in 1855, John Humphrey took up an appointment at a new civil hospital near Constantinople.[45] Barber left because of ill health, and Fernie resigned due to the heavy workload.[46] A few were appointed to public posts locally, for instance as Public Vaccinator in 1869 and two as district MOs in the 1890s. Edmund Whitcombe received his medical education at Sydenham College in Birmingham and was appointed WMO the year after becoming MRCS.[47] He resigned 18 months later to take up the post of Assistant Medical Superintendent at the Borough Lunatic Asylum and was appointed to a chair of mental diseases at the University of Birmingham in the late 1880s (Table 4.1).[48] Charles Mitchell left to set himself up in private practice and Ebeneezer Teichelmann to return to his native Australia. William Sturrock was called up for active service in

[43] BCL, BBG, GP/B/2/1/55, 5 January 1887.
[44] In the 1860s, the starting salary of the medical officer at the Battle Workhouse was £120; see Railton and Barr, *Battle Workhouse and Hospital, 1867-2005*, Reading, 2005, p.16.
[45] BCL, BBG, GP/B/2/1/15, 4 April 1855.
[46] He used the words 'unremitting duties' in his resignation letter; see quote as part of heading.
[47] Sydenham College was a rival medical school to Queen's College in Birmingham.
[48] BCL, BBG, GP/B/2/1/39, 10 August 1870; Anonymous, 'Obituary. Edmund Bancks Whitcombe', *British Medical Journal*, i (1911), p.1353.

1914, having joined the Territorial Army six years before.[49] In general, there were few WMOs in Birmingham who left public service and were appointed to positions at local voluntary hospitals, one exception being Redfern Davies, who was honorary surgeon to Birmingham Children's Hospital three years after resigning from the workhouse. As those acting as resident MOs in workhouses were at an early stage in their careers, poor law records rarely contain detailed information about their practices after resignation. However, part-time workhouse MOs could hold honorary appointments at voluntary hospitals in addition to their poor law duties, for instance, Dr L. M. Guilding at Battle workhouse was also assistant surgeon at the Royal Berkshire Hospital.[50]

Humphrey's workload increased when around 250 children were transferred from the Infant Poor Asylum to the new workhouse a few months after it opened in 1852 and his salary was increased by £25.[51] He complained that he had attended over 1,048 patients in that year, with 706 coming under his care within the previous six months, and he felt the strain of being the only MO on site.[52] He requested help in the form of an articled pupil, as was allowed to the district MOs. The guardians agreed but the PLB refused, because it would have permitted someone to be resident in the workhouse and not be directly responsible to the guardians through the master.[53] Two years later, he repeated his request for assistance, as attending the large number of patients in the infirmary and the sick wards of the workhouse (721 in total) reputedly left him completely exhausted at times. It also meant that he was not able to give

[49] BCL, BBG, GP/B/2/1/39, 10 August 1870; Advisory Sub Committee, GP/B/2/8/2/1, 23 September 1914.
[50] Railton and Barr, p.90.
[51] BCL, BBG, GP/B/2/1/11, 6 October 1852. The Asylum for the Infant Poor had been in use since 1797 for pauper children; see chapter 1 for details.
[52] BCL, VGPC, GP/2/8/1/1, 31 December 1852.
[53] BCL, BBG, GP/B/2/1/12, 5 January to 5 February 1853.

patients all the attention they deserved.[54] At his suggestion, a non-resident dispenser was appointed at an annual salary of £75.

Humphrey's successor in 1855 was William Fernie. However, Fernie resigned within two years because the pressure of his 'unremitting duties' left no opportunity for relaxation.[55] In his testimonial, the guardians accepted that his duties were 'onerous' because of the 'crowded state' of the workhouse, but took no action to rectify matters and merely advertised for a replacement.[56] One of the two candidates selected for interview for the vacant post was assistant surgeon at St Pancras Workhouse, but he withdrew his candidacy when he discovered the extent of the duties at Birmingham.[57] The successful candidate was John Wilmshurst, who was resident MO at Birmingham Lying-in Hospital, but when his request in the first year of his tenure for additional help was turned down, he resigned three months later. The reason the guardians gave for their refusal was that other large workhouses in England, such as City of London, Clifton, Greenwich and Lambeth, had only one MO, although Manchester, St Marylebone and Nottingham had two.[58]

In 1864, Edmund Robinson, after two years in post, reported that his workload had significantly increased, so that he was occupied all of the day and part of the night with his workhouse duties.[59] His request for an increase in salary, rather than for assistance, was granted, raising his remuneration from £200 to £250 *per annum*. In

[54] BCL, BBG, GP/B/2/1/15, 28 February 1855. His exact phrase is quoted in the heading of the chapter and his detailed quote is available in A. E. S. Ritch, '"Sick, Aged and Infirm'' Adults in the New Birmingham Workhouse, 1852–1912' (unpublished MPhil dissertation, University of Birmingham, 2010), p.51.
[55] BCL, BBG, GP/B/2/1/19, 8 April 1857; the words were underlined in his letter to the guardians in the Board minutes
[56] Ibid., 15 April 1857.
[57] Ibid., 6 May 1857.
[58] BCL, LGB Returns, GP/B/18/2/1, 15 October 1856.
[59] Ibid.

Edward Smith's report on provincial workhouse infirmaries in 1866, Robinson is recorded as being satisfied with his workload and did not need assistance, in spite of having to care for between 600 and 700 sick inmates. Interestingly, his salary had by then been increased to £350 annually and this level would not have been possible with additional medical personnel.[60] Commenting on Smith's report, *The Lancet* praised Birmingham workhouse as one of the best managed in the provinces, but found it hard to believe 'that the whole of these 600 sick are properly attended to, even granting the chronic nature of a large number of the cases'.[61] The employment of only one MO was also severely criticised in 1865 by a local doctor who found it unbelievable that 'a rich and progressive town like Birmingham' would permit 'an infirmary containing 599 beds to be officered by one medical man'.[62] In early 1874, *The Lancet* once again criticised Birmingham guardians for employing only one resident MO, suggesting that 'the medical supervision of the infirmary, with its 958 patients, must be merely nominal'.[63] A few months later, following a LGB inspector's criticism of the adequacy of the staffing of the medical department, the guardians eventually agreed to the appointment of an assistant medical officer (hereafter AMO), at an annual salary of £100.[64] However, Cuthbert Fitzsimmon was not appointed until June 1876, but both he and his successor, Aird Jolly, remained in post for less than a year. Charles Mitchell followed them in 1877 and eleven years later he was promoted to WMO.[65]

[60] Ibid.; British Parliamentary Papers (hereafter BPP), 1867-68 (4), p.43.
[61] Anonymous, 'Dr. Edward Smith's Reports on the Treatment of the Sick in Selected Provincial Workhouses', *The Lancet*, i (1868), p.166.
[62] T. P. Heslop, 'The Medical Aspects of Birmingham' in S. Timmins (ed.), *Birmingham and the Midland Hardware District*, London, 1866, pp.701-2.
[63] Anonymous, 'Birmingham', *The Lancet*, i (1874), p.109.
[64] BCL, VGPC, GP/B/2/8/1/6, 13 March 1874, 2 July and 29 November 1875.
[65] Further detail of the AMOs can be found in Ritch, '"Sick, Aged and Infirm"', pp.47, 49.

A subcommittee was set up in October 1877, at the instigation of the LGB, to consider medical and nursing arrangements in the workhouse. The WMO, Adam Simpson, considered that he had had no particular difficulty in performing his duties before an assistant was appointed, but admitted there was more work with the patients than he could perform, although he had given them satisfactory attention. He had needed to work hard, but had 'broke down' on occasions, so that it was not the patients who had suffered, 'rather it was himself'.[66] Simpson estimated that three MOs were needed to provide sufficient care for the number of patients, which he put at 900 to 1,000. The two assistants would share the work between them and visit their patients daily; he would provide supervision and be available for consultation over difficult cases.[67] Charles Mitchell, AMO agreed that patients did not suffer, but they were liable to be overlooked and with more time, could be more carefully examined. Mitchell spent from 9.00am to 12 noon daily going round the wards and seeing people in the body of the house and saw admissions in the afternoon. He was called up at night about twice per week.[68] The subcommittee recommended the appointment of a third MO to improve the medical care of patients. When Suckling was appointed visiting physician in 1882, he took charge of the medical wards, leaving Simpson to cover the surgical wards. The assistants were divided between the medical and surgical departments and when Jordan Lloyd took up office as visiting surgeon five years later, he became responsible for the surgical wards of the infirmary. The central authority had finally recognised the need for adequate medical staffing in workhouses. The guardians on the subcommittee in 1877 were impressed by the large number of acutely ill patients, which had turned the workhouse into 'a large Hospital containing

[66] BCL, Workhouse Inquiry Sub Committee (hereafter WISC), GP/B/2/3/11/1, 24 January 1878.
[67] Ibid.
[68] Ibid., 22 March 1878.

cases of so many various kinds of disease'.[69] In doing so, they were recognising in their own institution the national trend toward the increasing involvement of workhouses in medical care and this development will be explored in the next section.

Developing the Infirmary into a General Hospital

After the new Birmingham infirmary opened in 1889 on a separate site adjacent to the workhouse, the medical staffing began to be aligned with that of the voluntary hospitals. The two AMOs in the workhouse were transferred as resident surgeons and Charles Mitchell, who had been acting as WMO, was appointed to the post on a substantive basis. The visiting physician and surgeon had their duties apportioned between the two institutions, with the majority of their time spent at the new infirmary. An editorial in *The Lancet* was once again extremely concerned that the medical staffing was inadequate, stating:

> The 1,700 beds will... be occupied by sick persons requiring active medical supervision and treatment. For this number of persons there is to be a medical staff consisting of a visiting physician and a visiting surgeon, and two resident assistant medical officers… there is to be no medical superintendent. We have no hesitation in saying that it is impossible the sick can be properly cared for under these circumstances. The varying wants of sick people needing personal attention requires a detailed supervision, of which there can be none in the Birmingham Infirmary.[70]

In a letter of reply the following week, Cornelius Suckling, visiting physician, defended the staffing arrangement by pointing out there would also be two qualified resident clinical clerks, so giving a complement of six MOs and that many patients

[69] BCL, VGPC, GP/B/2/8/1/7, 3 May 1878.
[70] Anonymous, *The Lancet*, ii (1888), pp.1244-45.

suffered chronic ailments, not requiring frequent examination. Throughout the previous six years, Suckling had paid a daily visit, usually lasting two hours, during which he examined 'every fresh case' on the medical side, commencing treatment, and any case in which the resident officers required help. He claimed that in his time at the workhouse, more clinical reports had been published in the medical journals and more cases shown at medical societies from the infirmary than any other in the country, proving that the 'cases there are gone into properly'.[71] His account was challenged by an anonymous WMO, who doubted that Suckling's stated workload could be completed in two hours.[72] Three years after the infirmary opened, improved arrangements for medical staffing were introduced, with the appointment of two additional visiting physicians (Table 4.2). Each of the physicians and the surgeon was allotted one of the resident MOs, who rotated every six months.[73] The resident officers held office for short periods of time, sometimes being succeeded by one of the clinical clerks. In the early 1900s, the tenure of the posts was fixed at one year, but with renewal possible.[74] The majority of the visiting physicians were of high professional standing in the town, with honorary posts at the voluntary hospitals. Otto Kauffman, for example, became Professor of Medicine at the University of Birmingham, after visiting posts at the infirmary were abolished in 1913.[75] At this time, Frederick Ellis FRCS, MD was appointed Medical Superintendent at an annual salary of £750, to increase incrementally to £1,000.[76]

[71] Ibid., p.1308.
[72] Anonymous, 'Birmingham Workhouse Infirmary', *The Lancet*, i (1889), p.47.
[73] BCL, Workhouse Infirmary Management Committee (hereafter WIMC), GP/B/2/4/4/2, 28 January 1893, 25 January 1894.
[74] BCL, WIMC, GP/B/2/4/4/4, 8 May 1903.
[75] Hearn, p.23.
[76] BCL, Birmingham Union Board, GP/B/2/1/81, 19 March 1913.

Table 4.2: Visiting Surgeon and Physicians to Birmingham Infirmary, 1882-1913

Name	Time in Office	Annual Salary	Reason for termination
Surgeon:			
George Jordan Lloyd	January 1887 - April 1913	£150 - £200	Died
Physicians:			
Cornelius Suckling	November 1882 - January 1892	£150 - £200	Resigned due to pressure of private practice
Alfred Carter	April 1892 - April 1898	£100	Resigned
John Barrett	April 1892 - January 1893	£100	Resigned as he had insufficient practical experience
Sydney Short	April 1892 - June 1913	£100	Post abolished
Otto Kaufman	April 1893 - June 1913	£100	Post abolished
Thomas Wilson	May 1898 - March 1903	£100	Resigned
Ross Jordan	April 1903 - June 1913	£100	Post abolished

Source: BCL, BBG, GP/B/2/1/50-82, 1887-1913.

After the new infirmary opened in 1889, the WMO, Charles Mitchell, continued to have a heavy workload, as not all patients had been moved to the new institution. Initially, he had the support of the visiting physician and surgeon, who had a minor portion of their duties allocated to the workhouse. The visiting physician's input lapsed when Suckling resigned, but was restored two years later with the appointment of the senior physician at the infirmary, Alfred Carter, at an annual salary of £25. However, when four years later, he had not completed the required reports for almost a year and did not have evidence to prove his attendance at the workhouse, he was asked to resign.[77] No subsequent appointments appear to have been made. The WMO spent a considerable amount of his time seeing patients in the venereal and

[77] BCL, Workhouse Management Committee (hereafter WMC), GP/B/2/3/2/2, 27 April 1894, 11 March 1898.

bedridden wards. He spent two and a half hours each morning examining tramps and outpatients and visited the receiving wards five times each day between noon and 10.00pm. He admitted 30 to 40 inmates daily, with each one taking up to 15 minutes, so that he could be busy until 11.00pm.[78] In addition, all potential admissions to the infirmary had to be seen at the workhouse by the WMO. In 1880, the board of guardians decided that it was not desirable for patients to be admitted directly to the infirmary and this policy had the LGB's approval.[79] This practice continued into the first decade of the twentieth century, although the majority of unions had accepted by then that the principle of deterrence no longer applied to sick paupers.

Having only one resident medical attendant in the workhouse returned the institution to the inadequate level of medical staffing of the 1870s. Difficulties in medical attendance arose when the WMO was on afternoon and occasional leave. The resident infirmary medical officers (hereafter IMOs) were required to perform his duties at these times, but it was often difficult to obtain their assistance. Delays occurred because of the time they took to arrive at the workhouse, after being called to see new admissions or sick inmates in the wards. This often arose because they were busy with duties in the wards or accompanying the visiting physicians.[80] Eventually, in 1903, the Infirmary House Sub-committee recommended that all cases sent to the workhouse by the DMOs, as well as ambulance cases, should be received directly at the new infirmary lodge, during these periods of leave.[81] However, that did not solve the problem of attendance to sick patients arriving at the workhouse on their own initiative. On one occasion in January 1904, a man in pain arrived at the

[78] Ibid., GP/B/2/3/2/1, 11 April 1890.
[79] BCL, HSC, GP/B/2/3/3/7, 22 June 1880.
[80] BCL, Infirmary House Sub-committee (hereafter IHSC), GP/B/2/4/5/3, 21 December 1903.
[81] Ibid.

workhouse at 3.40pm, 40 minutes after the WMO had left, and the IMO had not turned up to see him by 6.00pm, when a further telephone message was sent. After several more telephone calls, Dr Cooper eventually arrived at 7.40pm, but the patient had not waited, returning the next day to be admitted to the infirmary.[82] A further incident occurred three years later, also involving Dr Cooper. Night nurse Crocker had telephoned him at 9.00pm to see Thomas Jeffrey with a 'very bad ulcerated leg' in the probationary ward. He arrived an hour later, was annoyed at being called, made a cursory examination of the wound and ordered the patient to the tramp ward without prescribing a dressing.[83] These were not the only problems resulting from the WMO being sole resident in the workhouse, available both day and night. For instance, on one occasion in 1901, William Sturrock apologised for the four-hour delay in attending a patient, Edward Porter. Sturrock had been called out of bed three times during the night then taken a 'sedative draught to obtain sleep'. After Nurse Brisbane called him at 6.30am to see Porter, he had gone off to sleep again and the nurse did not call a second time.[84] At that time, the 959 non-able-bodied and 575 able-bodied, but temporarily disabled, inmates present in the workhouse were likely to impose a heavy workload on the WMO.[85] Difficulties in providing adequate medical care due to large numbers of patients also occurred in Wolverhampton workhouse.

[82] BCL, HSC, GP/B/2/3/3/21, 26 January 1904.
[83] BCL, HSC, GP/B/2/3/3/19, 11 April, 11 July 1899; GP/B/2/3/3/22, 8 January 1907.
[84] BCL, HSC, GP/B/2/3/3/20, 10 September 1901.
[85] BCL, LGB Returns, GP/B/5/1/3, 2 October 1901.

Part-time Medical Attendance in Wolverhampton Workhouse

The advantage of appointing WMOs on a non-resident, part-time basis and allowing them to practice privately in addition was that they were more likely to stay in post for many years, providing greater continuity of medical care. This was the arrangement in the first Wolverhampton workhouse, providing a contrast to that in Birmingham, but was more in keeping with most moderately sized workhouses in England. The first two WMOs also acted as district officers, but after 1852, district work was separated from that in the workhouse (Table 4.3). All MO posts were advertised for tender in 1839, and Charles Hodgkin was appointed to the workhouse at £25 *per annum*.[86] Following re-advertisement two years later, George Cooper took over the workhouse and Charles Hodgkin one of the districts.[87] Thereafter, the WMOs remained in post for many years (just over 13 years on average), usually until they died or were asked to resign by the guardians. Only Richard Nugent resigned voluntarily, presumably to take up another appointment, as he had requested a testimonial three weeks before his resignation.[88] Wolverhampton MOs rarely requested assistance when their workload increased, preferring to ask for an increase in salary. George Cooper requested a bonus, because of the influx of patients suffering from fever, but was rejected, even though the guardians accepted his duties had been onerous during the crisis, which had broken out in some lodging houses. Their reason was that it was a contingency to which all contracts were liable. Mr Perks, one of the guardians, was particularly unsympathetic, stating that 'when the medical officer took his situation, he took it as a man took his wife, for better or

[86] Wolverhampton Archives and Local Studies (hereafter WALS), Wolverhampton Board of Guardians minutes (hereafter WBG), PU/WOL/A/2, 19 March 1839.
[87] Ibid., PU/WOL/A/3, 19 March 1841.
[88] Ibid., PU/WOL/A/10, 28 October, 18 November 1859.

worse'.[89] When Nugent's salary was increased within a year of his appointment, it was on condition that he attended every case of midwifery to which he was summoned promptly, and the nurse was directed to call him as soon as any difficulty was suspected.[90] Henry Gibbons' salary was increased in 1866, to enable him to take on an assistant to carry out the dispensing.[91] He supported his case by pointing out that the workhouse infirmary had 300 beds and the annual number of cases was 1,706. Whereas, at the local voluntary hospital, there were only 100 beds, with 750 cases in the year, and the patients were cared for by eight 'medical men' and two pupils.[92] Eight years later, the guardians agreed to pay the salary of a dispenser (£20 *per annum*) without altering Gibbons' salary.[93] At the beginning of the twentieth century, a LGB inspector questioned whether the MO's two hours in the workhouse daily were sufficient to provide satisfactory care and suggested a resident officer should be appointed. A motion to the board of guardians to do so was defeated, but it was agreed to appoint a dispenser at a salary of £130 per annum.[94] Agreement to appoint a resident MO was reached prior to the opening of the new workhouse in 1903.[95] Surprisingly, considering the proposed increase in infirmary accommodation from 230 to 360 beds, Thomas Galbraith requested the decision be rescinded and the current arrangement remain in place, with himself as sole MO.[96] The guardians decided to proceed with the appointment and George Anderson commenced in January 1904 with an annual salary of £130. His duties included examining all tramps daily, dispensing on Sundays and at other times in the absence of the

[89] Ibid., PU/WOL/A/6, 9 July 1847; *Wolverhampton Chronicle* (hereafter *WC*), 7 July 1847.
[90] WALS, WBG, PU/WOL/A/8, 24 June 1853.
[91] Ibid., PU/WOL/A/13, 5 October 1866.
[92] Ibid.; *WC*, 30 October 1866.
[93] WALS, WBG, PU/WOL/A/16, 11 December 1874.
[94] WALS, General Purposes Committee (hereafter GPC), PU/WOL/D/1, 28 February 1901.
[95] WALS, WBG, PU/WOL/A/29, 10 May 1901; PU/WOL/A/30, 28 August 1903.
[96] Ibid., 10 August 1903.

dispenser, administering anaesthetics, lecturing to and instructing probationer nurses.[97] Among the eleven applications for the post, two were female, but they were summarily rejected.[98] Anderson remained in post for eight years and was replaced by William Coghill, who obtained a post in Coventry three years later.

Some poor law historians have been critical of part-time poor law MOs for their lack of attendance on sick paupers and for leaving this task to their unqualified assistants.[99] However, both Brand and Ruth Hodgkinson point out that it is not possible to assess their efficiency with any degree of accuracy as the complaints of the sick poor were rarely recorded.[100] The Wolverhampton guardians, in a special meeting in 1890, included in the regulations for the MO that he must attend at least once daily. Four years later, they required that he should arrive no later than 10.30am every morning.[101] However, when the occasion demanded it, officers could spend long periods in the workhouse. George Cooper was in attendance from 5.00am one morning in June 1845 to attend a woman with a difficult and protracted labour and he stayed till she had given birth at noon.[102] On an earlier occasion, the labour of 'E. D.' was also protracted and the master reported that the safety of the mother and child was due to Cooper's skill and the 'great attention' he gave to the delivery.[103] Despite this dedication, the infrequency of his attendance at the workhouse became a source

[97] WALS, WBG, PU/WOL/A/30, 18 December 1903.
[98] Ibid., 2 December 1903.
[99] Crowther, *Workhouse System*, p.163; S. Fowler, *Workhouse: The People, The Places*, *The Life Behind Doors*, Richmond, 2007, p.156; J. Lane, *A Social History of Medicine; Health, Healing and Disease in England, 1750*-1950; Loudon, *Medical Care*, pp.50, 63; A. Digby, *Pauper Palaces*, London, 1978, p.171.
[100] Brand, 'Parish Doctor', p.122; Hodgkinson, 'Poor Law Medical Officers', p.311.
[101] WALS, Resolutions re. Duties of Officers, PU/WOL/L, 27 October 1890; Workhouse Visiting Committee (hereafter WVC), PU/WOL/H/1, 16 March 1894.
[102] WALS, Master's Journal (hereafter MJ), PU/WOL/U/2, 7 June 1845.
[103] Ibid., 4 November 1843; for further information on midwifery in Wolverhampton workhouse, see F. J. Badger, 'Delivering maternity care: midwives and midwifery in Birmingham and its environs, 1794-1881' (unpublished PhD thesis, University of Birmingham, 2014), pp.232-35.

of conflict between Cooper and the guardians eight years later. Because of discrepancies between the entries in the medical report book and porter's book relating to his times of attendance, he was reprimanded after being found guilty of 'gross carelessness in bookkeeping' and inflating the amount of time he spent in the institution. However, the board did so reluctantly because of his previous good service.[104] Around this time, the PLB had informed the guardians that Cooper was entitled to hold his appointment on a permanent basis.[105] However, the guardians wished him to forgo the permanency by resigning in the following March and recorded his verbal agreement in the board minutes. Cooper maintained that he was opposed to resigning as he approved of the PLB's ruling on the permanency of MO appointments and he had merely agreed to respond in writing to the guardians' formal request for his resignation.[106] Subsequently, further charges of failing to enter details

Table 4.3: Workhouse Medical Officers in Wolverhampton Workhouse, 1839-1914

Name	Time in Office	Annual Salary	Reason for termination
Charles Hodgkins	March 1839 - March 1841	£40	Retendering process
George Cooper	March 1841 - September 1852	£40 - £80	Requested to resign
Richard Nugent	October 1852 - December 1859	£80 - £130	Resigned
Henry Gibbons	December 1859 - April 1882	£130 - £180	Died
Edward Watts	April 1882 - August 1894	£130 - £180	Died
Thomas Galbraith	September 1894	£175 - £200	In post in 1914

Source: WALS, WBG, PU/WOL/A/2–25, 1839-1914.

[104] WALS, WBG, PU/WOL/A/8, 17 October 1851.
[105] WALS, *WC*, 24 September 1851.
[106] TNA, MH12/11650, 30 December 1851.

of patients with infectious disease in the medical relief book were laid, with the implication of medical negligence.[107] However, it is likely the guardians were looking for a way to terminate his contract, as he had not complied with their request for his resignation.

Conflict between the Guardians and the Medical Officers

Disputes between MOs and guardians over conditions of employment and conditions within the workhouse were numerous, with guardians frequently ignoring their requests for treatment and improvement to workhouse conditions. A power struggle between MOs and guardians or other workhouse officials often resulted in charges of medical negligence. The medical ethos of striving to cure patients was at variance with the principle of less-eligibility, which prevailed in keeping the standard of medical welfare low. Price carried out an extensive study of the employment, disciplining and dismissing of WMOs of the NPL.[108] He demonstrated that most charges for negligence arose out of the issues of attendance and record keeping.[109] Extremely low salaries, the conflict between doctors' private and public duties and their immense workload were instrumental in making it virtually impossible to attend to all ill inmates promptly. However, there have been few studies of this aspect of their work. Reforming MOs were at greater risk of being charged, but almost 40% of

[107] WALS, WBG, PU/WOL/A/8, 7 November, 21 November, 12 December 1851.
[108] K. Price, 'A regional, quantitative and qualitative study of the employment, disciplining and discharging of workhouse medical officers of the New Poor Law throughout nineteenth-century England and Wales' (unpublished PhD thesis, Oxford Brookes University, 2008).
[109] R. Klein has demonstrated that failure to visit was the second commonest cause of dissatisfaction with general practitioner services in the 1970s, with the manners of practitioners being the first; *Complaints against Doctors*, London, 1973, pp.105, 116.

WMOs were disciplined throughout the nineteenth century.[110] The tightening of the rules of employment in 1871 and the subsequent crusade against outdoor relief, which was extended to include medical relief, was a 'barely concealed attempt to set PL MOs up as the nation's "fall-guy"'.[111] It made negligent practice a necessity and charges of negligence increased markedly in the 1870s. Guardians could create 'groundless charges' to rid themselves of troublesome MOs and, as a result, doctors bore the brunt of failings in poor law medical practice.[112] Before considering the events in Birmingham and Wolverhampton, it is necessary to have an understanding of the context in which they arose. In the nineteenth century, a doctor's practice was judged on the basis of what 'an ordinary man' would consider reasonable, rather than by standards set by the medical profession.[113] MOs were viewed as providing a service similar to any business, and failure to carry it out efficiently was regarded as negligence. This differs from the twentieth-century concept of negligence, which is failure to practise acceptable standards of clinical care.

The frequency of visits to the workhouse was a common cause of conflict between guardians and MOs in Wolverhampton. The report of the enquiry into the charges of negligence against Cooper, WMO, in December 1851, referred to earlier, was generally favourable to him, but he was severely reprimanded by the guardians. The seven charges mostly reflected his non-attendance and poor bookkeeping. First, he had neglected to see Ellen Dunnock, a sick child, who had died twelve hours after admission to the workhouse in the early evening. He had confined William Newell in

[110] Price, 'Quantitative and qualitative study', p.342.
[111] Ibid., pp.141, 230.
[112] K. Price, '''The Shape of the Iceberg'': Doctors and Neglect under the New Poor Law, c.1871-1900', in J. Reinarz and R. Wynter (eds), *Complaints, Controversies and Grievances in Medicine*, London, 2014, p.138.
[113] Ibid., p.136.

the lunatic wards for three days as punishment, but omitted his name from the list of patients in those wards. For 69 hours from one Saturday, he had been absent without leave and failed to provide a deputy, and in that time Thomas Franks, nine years old, was admitted badly burnt. Franks did not receive medical attention for 26 hours, only being seen one hour before he died. Cooper had not attended to Lydia Gidderidge during her 58-day stay in the workhouse and omitted her name from the medical relief book. He had failed to record many of the episodes of illness among the children. Thomas Day, a lunatic, had been confined to bed by means of straps for several days, but he had not recorded it, nor reported it to the guardians, who had recently expressed their disapproval of such treatment. The way he treated individual inmates was the subject of only one charge, in which he was accused of acting 'contrary to decency'. He had allowed between 20 and 30 boys and girls, of around ten years old, to be in a 'state of nudity' in one room together, while they were being treated for skin disease. Similarly, two adult males suffering from venereal disease were left naked in a ward with other inmates present.[114] The PLB's enquiry blamed these instances on the breakdown in the proper classification in the workhouse and so the treatment of the inmates was not directly attributable to Cooper. Nevertheless, the board censured him for not bringing the guardian's attention to the lack of classification.[115] In doing so, the PLB was giving higher priority to the administration of the workhouse than to the personal dignity of its inmates. The guardians had hoped that the warning from the PLB would secure for the inmates 'that amount of professional attention' that the guardians wished.[116] However, within a few months, errors in bookkeeping and complaints by inmates regarding Cooper's treatment continued. Following a further

[114] WALS, WBG, PU/WOL/A/8, 19 December 1851; *WC*, 11 February 1852; TNA, MH12/11680, 30 December 1851.
[115] WALS, *WC*, 11 February 1852.
[116] WALS, WBG, PU/WOL/A/8, 20 February 1852.

enquiry by Andrew Doyle, PLB Inspector, Cooper was requested to resign in the 'interests of the Union'.[117] Dr Mannix, one of the guardians, was of the opinion that Cooper had initially been 'an active and efficient officer', but had later 'relaxed' for reasons he could not fathom.[118] One likely reason could have been a burgeoning private practice, since tension between public and private responsibilities often resulted in difficulty attending the workhouse.[119]

Cooper's successor as WMO, Richard Nugent, was investigated for poor attendance at the workhouse within a few years of his appointment. He had recorded in the medical relief book in 1855 that he had visited every patient daily, whereas he was accused of failing to see Josiah Tomkinson, aged seven years, despite being requested to do so on two occasions. When he did see him, eight days before the boy died, he diagnosed skin disease, but entered 'scrofula, rickets and spinal' on the death certificate.[120] Nugent was admonished by the guardians, who agreed to his request not to inform the PLB after he had given them an explanation of his conduct.[121] One month later, he was reappointed as MO with 57% of the guardians' votes in an election involving three other candidates.[122] However, within a few weeks, inmate Benjamin Lane complained of not receiving treatment from Nugent, whose explanation on this occasion was judged unsatisfactory. The PLB were notified and subsequently issued Nugent with a censure, pointing out the importance of listening to the complaints of sick inmates with patience.[123] Three months later, Nugent's

[117] Ibid., 25 June, 16 July 1852; *WC*, 29 September 1852.
[118] WALS, *WC*, 10 December 1851.
[119] Price, 'Quantitative and qualitative study', p.231.
[120] WALS, WBG, PU/WOL/A/9, 9 February 1855; *WC*, 14 February 1855.
[121] WALS, WBG, PU/WOL/A/9, 16 February, 23 February 1855.
[122] Ibid., 16 March 1855.
[123] Ibid., 30 March, 13 April, 18 May 1855; *WC*, 23 May 1855; details of the treatment received by Lane can be found in Chapter 5.

conduct in the management of Mary Shaw was also called into question. She had developed severe abdominal pain, which worsened the same evening, so that she requested Nugent be called to see her. He attended between 8.00pm and 9.00pm, but threw off her bedclothes in what the nurse described was 'an indecent manner' and examined her very roughly. He was obviously in a 'very bad temper' and used threatening language when Mary complained of headache. Nugent admitted to the guardians that he was annoyed at being called out by the matron, as she had no authority to do so, and to 'a simple case' of abdominal pain. When requested to apologise for the language he had used, Nugent denied that he had been abusive, but was prepared to make an apology if the board were of the opinion that he said what the inmate and nurse had reported. The board stopped short of dismissing him, instead issuing a final warning.[124] No further disagreements over Nugent's attendances occurred for three years, but at that time the guardians had a return prepared detailing his conduct over two years. Nugent or his deputy had attended the workhouse for 539 days (74%) in the period, although the chairman of the guardians pointed out that they had often visited when there were no patients needing attention. The average length of visits was 62 minutes, but could be as short as five to 20 minutes, even when there were 200 sick inmates in the workhouse. Discussion of the report was postponed, but there is no record that it subsequently took place before Nugent resigned the following year to take up another appointment.[125] By comparison, the MO for Nottingham workhouse spent on average two hours and a half on his daily visits in 1866, with an average 300 patients under his care.[126]

[124] WALS, WBG, PU/WOL/A/9, 27 July 1855; *WC*, 1 August 1855.
[125] WALS, WBG, PU/WOL/A/10, 23 February 1858; *WC*, 11 August 1858; 28 September 1859.
[126] BPP, 1867-68 (4), p.125; Bosworth, pp.236-37.

His successor, Henry Gibbons, was in post for over 22 years, and the only complaint regarding his conduct took place two years after his first leave of absence due to ill health in 1870. However, he had previously been reported by the LGB to the guardians for failing to enter the dates of an order for medical extras in the medical relief book.[127] In April 1877, Patrick Reddington, an inmate of the workhouse, complained to the LGB about his treatment on admission, but the guardians found 'no cause for complaint' against Gibbons.[128] Two years later, he was again off work, but this time for around six months, prompting the guardians to consider whether to grant continuing leave. However, one of them commented that sick inmates were 'perfectly satisfied' with the attention Gibbons gave them and he was able to resume his duties shortly thereafter.[129] When he died suddenly in April 1882, approximately 50 years of age, the guardians' response suggested admiration.[130] Edward Watts was exonerated by the guardians after a complaint from Mrs Blower regarding her treatment in the workhouse, while he was deputising for Gibbons in August 1881.[131] After Gibbon's death, he was elected as MO on the casting vote of the chairman of the board, defeating four other candidates.[132] A further complaint, in 1890, of neglecting William Thomas, a patient in the infirmary, also found Watts was not to blame.[133] However, after sustaining an accident a few months later, lapses in his performance started to arise. In May the following year, the board's auditor reported errors of omission and accuracy in the medical relief book, all of which were accepted by Watts and he was cautioned to be more careful in his record keeping.[134] The

[127] WALS, WBG, PU/WOL/A/14, 2 December 1870.
[128] Ibid., PU/WOL/A/17, 27 April 1877.
[129] Ibid., 5 September 1879; *WC,* 13 August 1879.
[130] WALS, WBG, PU/WOL/A/19, 14 April 1882.
[131] Ibid., PU/WOL/A/18, 12 August 1881.
[132] Ibid., PU/WOL/A/19, 28 April 1882.
[133] Ibid., PU/WOL/A/23, 16 May 1890.
[134] Ibid., 15 May 1891.

following month, Watts failed to visit the workhouse for three days, following which the master requested the MO's deputy to attend. Watts's reason for his non-attendance was that he had been taken ill with influenza, but it is obvious he had failed to inform his deputy. Although the guardians were dissatisfied with his attendances over the previous three months, no action was taken against Watts after an exchange of letters between the guardians, Watts and the LGB.[135] A more serious charge of neglect of duty on the part of Watts related to the treatment of Joseph Freeman, an inmate who died on 8 June 1894, and the guardians requested an enquiry by the LGB. When Watts saw Freeman on admission, two days before his death, he was complaining of abdominal pain. Although Watts allocated him to the 'old men's' ward, the nurse later had Freeman transferred to the infirmary as his condition had deteriorated. Watts visited the workhouse the next day, but did not see Freeman, although he discussed his condition with the nurse. At the request of one of the guardians, who was medically qualified, he went to see Freeman and instigated treatment. Watts was also questioned as to why he had not attended a case of 'Acute Scorbutis' in the same ward when attending Freeman. His reply was that he did not think it necessary. The master reported that Watts was often in 'a muddled state' when visiting the workhouse.[136] Watts died before the LGB enquiry into his conduct over Freeman could be completed. It is clear that both Watts's and Gibbon's performance of their duties deteriorated when they suffered ill health, but strove to continue at work. Price found that almost one quarter of poor law MOs died in office due to many carrying on into old age, when they were more likely to make mistakes.[137]

[135] Ibid., 17 July, 21 August, 4 December 1891.
[136] WALS, WVC, PU/WOL/H/1, 15 June 1894.
[137] Price, 'Quantitative and qualitative study', pp.209-11.

This did not apply in Gibbon's case and was unlikely to have applied in Watts's case, as the majority of Wolverhampton's MOs were appointed in their 20s. One exception was Thomas Galbraith, who was in his early 30s when he succeeded to Watts's position as MO. He was still in office in 1914 and until that time, the only serious complaint against him arose once more because of illness. He needed reminding of the times he was required at the workhouse because of late and irregular attendance in his early years of appointment. It was also impressed upon him that his 'first and principal duties' were to the inmates of the workhouse.[138] Two years later, he was again requested to be more punctual as his later arrival at the institution disrupted the serving of meals.[139] Early in the twentieth century, a tramp, William Buck, complained that the MO had not seen him, although he had requested a visit on his arrival at the workhouse late one evening. Galbraith was unwell at this time and his deputy, Dr Carter, had left the workhouse before Buck arrived, but returned in the late evening to visit patients in the infirmary. He did not see Buck, as the nurse informed him that everyone in the tramp wards would be in bed and no one needed to be seen urgently. Carter did not visit the following day (Monday), as he assumed Galbraith would be fit for work and Buck left the workhouse early the following morning. He turned up at Walsall workhouse a day later and was diagnosed as having severe smallpox. The Walsall officials accused the Wolverhampton guardians of 'grave dereliction of duty'. Galbraith had set out for work on the Monday, but returned home, as he felt his physical strength was insufficient to continue and arranged a *locum tenens* from London. His sister had telephoned the workhouse to explain the arrangements, and had spoken to the superintendent nurse, who unfortunately did not inform the master. Galbraith regretted his illness had been the primary cause of the

[138] WALS, WVC, PU/WOL/H/2, 7 and 14 February 1896.
[139] Ibid., 7 April 1898.

'neglect in his duties', but felt he had done his best in difficult circumstances. Nevertheless, the board instructed Galbraith that, in future, he must ensure the master is made aware directly of the arrangements in place, if he is unable to attend.[140]

Over the period of this study, Reading Union workhouse employed three MOs on a part-time basis similar to Wolverhampton, but there are no recorded incidents of non-attendance or charges of neglect of duty.[141] Similarly, no charges were brought against the WMOs for Nottingham union. They were employed on a whole-time basis and not allowed to practise privately, but also had district duties. Although they were designated as resident, they were required only to live as close to the workhouse as possible.[142] Leicester Union WMOs had similar contracts to Wolverhampton and, while two remained in post for around ten years, one did so for 34 years. John Moore, appointed in 1857, suffered ill health toward the end of his ten-year appointment. When he failed to reduce a fracture of an inmate's leg, which developed gangrene and resulted in her death, he was asked to resign.[143] The longest-serving MO, Clement Bryan, was a lax record-keeper, which resulted in him being questioned several times, but no charges against his conduct in other matters were ever brought, and no complaints by patients about their treatment were recorded.[144]

By requiring WMOs to be resident, it might be assumed that Birmingham guardians had insured that attendance at the workhouse would not be an issue. However, the officers were not required to be present at all times, although their movement in and

[140] WALS, WBG, PU/WOL/A/30, 30 January 1903; House Committee (hereafter HC), PU/WOL/E/1, 29 January, 26 February 1903.
[141] Railton and Barr, *Battle Workhouse*.
[142] Bosworth, pp.235-43.
[143] Negrine, 'Medicine and Poverty', p.57.
[144] Ibid., pp.60-63, 66.

out of the workhouse was recorded in the porter's book. As a result, one surgeon, Redfern Davies (in post 1858-61) was required to resign because of insufficient time in the institution. He first came into conflict with the guardians over his attempts to carry out major operations in the workhouse, rather than transfer patients to the local voluntary hospitals, as preferred by the guardians. He defended his views vigorously at first, but eventually apologised and accepted he could only operate in the workhouse in cases of urgency and when the patient was unfit to be transferred.[145] Davies was an enthusiastic and ambitious surgeon, who published reports of his practice in the medical press. The son of a local physician and Birmingham's first coroner, Birt Davies, he had extensive local medical connections. After he had sustained an accident in December 1860, he thanked the guardians for allowing him leave to recover as he felt 'I should have broken my heart' if not permitted to return to work.[146] Around this time, it came to light that Davies had been absent from the workhouse on numerous occasions, although he had been accustomed to do so prior to his accident. He had been leaving the workhouse daily, usually for about five or six hours for health reasons and intended to continue to do so.[147] Although he initially declined to resign when requested by the guardians, he eventually agreed after they requested an enquiry by the LGB and he accepted that his absences were more numerous than he had thought, due to 'want of memory'.[148] It is possible that he did so to pursue medical interests elsewhere. The only other Birmingham MO to face charges of negligence was Adam Simpson, but before further discussion of his case, it is necessary to discuss puerperal fever, which was central to the cause of his dismissal.

[145] BCL, BBG, GP/B/2/1/23, 22 February, 8 and 22 June 1859.
[146] BCL, BBG, GP/B/2/1/26, 21 August 1861.
[147] BCL, VGPC, GP/B/2/8/1/3, 16 August 1861.
[148] BCL, BBG, GP/B/2/1/26, 25 September, 9 October 1861.

Puerperal fever was the major single cause of maternal death after childbirth, with a fatality rate of between 35% and 80%; the earlier the onset of the condition, the higher the mortality.[149] The disease reached epidemic proportions in lying-in institutions in the nineteenth century, although sporadic cases also occurred.[150] The commonest causative organism was *Streptococcus pyogenes*, discovered by Pasteur in 1879. The bacterium gained entry via the traumatised birth canal, resulting in local infection, including peritonitis, which could spread into the blood stream, causing septicaemia. Symptoms usually began a few days after delivery, with shivering, headache, vomiting, abdominal pain and high fever.[151] One of the earliest physicians to publish evidence of the contagious nature of the disease and of its transmission by midwives and doctors was Alexander Gordon in 1795, following an outbreak near Aberdeen. According to Loudon, Gordon's 'brilliant treatise' was neglected and forgotten because it could not be linked to generally accepted knowledge at that time.[152] Further evidence in support of the contagious theory was provided by Oliver Wendell Holmes in America in 1843 and Ignaz Semmelweiss in Vienna in 1847, the latter significantly reducing maternal mortality in hospital by instituting hand washing using a solution of chloride of lime.[153] However, both met with formidable opposition from the medical establishment, most likely due to the inference that doctors spread the disease. However, Loudon suggests that, by the 1850s, it was difficult for doctors to plead total ignorance of the part played by contagion.[154] For 20 years from the mid-1860s, the contagious versus miasmic nature of puerperal fever attracted considerable

[149] I. Loudon, *The Tragedy of Childbed Fever*, Oxford, 2000, p.6; this is the major text devoted to the history of puerperal fever.
[150] M. Dobson, *Disease, the Extraordinary Stories Behind History's Deadliest Killers*, London, 2007, p.72; Loudon, *Childbed Fever*, p.6.
[151] W. F. Bynum, *Science and Practice of Medicine in the Nineteenth Century*, Cambridge, 1994, p.205; Loudon, *Childbed Fever*, p.5.
[152] Loudon, *Childbed Fever*, pp.13, 32.
[153] Ibid., pp.92-93.
[154] Ibid., p.106.

attention by the medical press and, by the end of this time, most British lying-in hospitals had adopted Joseph Lister's methods of antisepsis, with a subsequent decline in maternal mortality.

Adam Simpson, LRCS, Ed., was born in county Tyrone in Ireland in 1836 or 1837. He remained single and after he left the service of Birmingham workhouse, he lived in nearby Gillott Road with his unmarried sister.[155] He was appointed WMO in August 1870, but the records for that period of the Visiting and General Purposes Committee, which recommended his appointment to the board, are missing from the archives. He suffered at least four episodes of ill health in his first five years in office, one of which was described by the master as a 'serious illness'.[156] When he unsuccessfully applied for the post of surgeon to West Riding Prison in 1875, the guardians' testimonial stated he had given them 'utmost satisfaction' in the performance of his duties.[157] Medical assistance in the workhouse increased in 1876 with the appointment of an AMO and again two years later, when a further assistant was appointed. With the appointment of a visiting physician in 1882, Simpson's duties were limited to the surgical side of the infirmary.

The first LBG enquiry into his conduct took place 16 months after the first AMO had been in post and it centred on whether the deaths of Henry Binks and a man named Washbrook were due to medical neglect. Simpson had admitted Binks to the

[155] In his will, he left a bequest to the National University of Ireland in Dublin on condition that Irish would be a compulsory subject in the university's matriculation examination. It became available to the university in 1923 and was used to fund a journal of Irish studies, *Eigse*, until 1999 and afterwards a post-doctoral fellowship; BCL, Register of Wills, 1913, pp.l469-72; http://www.nui.ie/eigse/journal history, accessed 26 June 2009; http://www.nue.ie/awards/research.asp, accessed 8 December 2009.
[156] BCL, BBG, GP/B/2/1/40, 27 December 1871; VGPC, GP/B/2/8/16, 30 August 1872, 2 January 1874, 16 April 1875.
[157] BCL, BBG, GP/B/2/1/44, 10 November 1875.

infirmary in the mid-afternoon after diagnosing bronchitis, but did not consider his condition needed urgent further attention. In the ward Binks was given milk, beef tea and a dose of the cough mixture kept on the ward when he became breathless. When seen again by Simpson at 8pm, he had deteriorated and was prescribed brandy and a linseed poultice for his chest. The cause of death was accepted as bronchitis by the coroner, but the jury at the inquest were of the opinion that Binks should have received earlier attendance. Simpson disagreed that this would have affected the outcome.[158] After the LGB requested the guardians to obtain his resignation, Simpson placed the matter before the board, remarking on the kindness and courtesy he had 'invariably received at [their] hands' over the previous seven years. The board considered he had not given 'all attention' required to Binks, but there was no direct evidence to 'inculpate' him in the Washbrook case. They concluded that censure was sufficient and gained the LGB's consent to retain him in office.[159] In deciding Simpson's future, the guardians, undoubtedly, took into consideration the remarks by the LBG that he had under his care more patients than he could properly attend to, even in the most cursory manner. They were also of the opinion that he was uniformly kind to his patients.[160] This incident led to the setting up of an enquiry by the guardians into the deficiency in medical and nursing staff in the infirmary and to the subsequent appointment of the second AMO. Four years later, Simpson was charged with using medical treatment as a punishment for patients by confining Ellen Peters, of reputed sound mind, in the padded room. There were also allegations by the Nurse Burns that blisters and shower baths were being used to punish Peters and Mary Jane Skett. Peters was a patient in the venereal ward and her conduct had been

[158] TNA, MH12/13326, 26 March 1877.
[159] BCL, HSC, GP/B/2/3/3/6, 1 May 1877; VGPC, GP/B/2/8/1/7, 21 September 1877; BBG, GP/B/2/1/45, 26 September, 24 October 1877.
[160] BCL, VGPC, GP/B/2/8/1/7, 21 September 1877.

strange, plus breaking windows, trying to cut her throat and 'exposing her person'. Skett had been in the imbecile wards for three years. Both claimed they had been subjected to shower baths and blisters as punishment and had been told as much by the two AMOs. At least one of the guardians found it difficult to believe that blisters were 'proper treatment'. At a local enquiry, Simpson did not directly deny the use as punishment, nor state they were used as treatment.[161] Price considers that the case was built on a contemporary grey area between methods of workhouse punishment and medical ideas on treatment of pauper lunatics.[162] Wolverhampton guardians made this distinction in 1902, when the MO sent William Lewis to the 'syphilitic ward' after he had been causing annoyance to other patients. Lewis was not suffering from venereal disease, but only one inmate on that ward was, because of no available space in the infirmary. After Lewis complained he had been transferred as a punishment, the guardians accepted that the MO had the authority to send patients to any ward he deemed best for medical treatment, but informed the MO it was improper to do so as punishment.[163] Baths and showers were used both as treatment and punishment in the early nineteenth century, and Leonard Smith has pointed out that the distinction between the two inevitably became intermingled.[164] Thus, Simpson's actions were in current use as medicinal treatments and he assessed the inmate involved as suffering from mental illness. The guardians referred the matter to the LGB as Simpson no longer retained their confidence, but the central authority merely censured him.[165] This incident led to the appointment of the visiting physician the

[161] TNA, MH12/13338, 17 December 1881.
[162] Price, 'Quantitative and qualitative study', p.315.
[163] WALS, HC, WOL/PU/E/1, 31 December 1902.
[164] L. D. Smith, 'Behind Closed Doors; Lunatic Asylum Keepers, 1800-60', *Social History of Medicine*, 1 (1988), pp.321-22.
[165] BCL, VGPC, GP/B/2/8/1/8, 9 December 1881; BBG, GP/B/2/1/49, 14 December 1881; BPP, 1886 (19-Sess. 2), pp.11, 22; Anonymous, 'Charge Against the Medical Staff of the Birmingham Workhouse', *British Medical Journal*, ii (1881), p.993.

following year. In December 1884, Simpson was called before the guardians for using 'improper language' to a nurse in one of the wards, which he explained was done in 'moments of irritation'. He was found to have interfered with the 'perfect harmony' required for the efficient running of the infirmary and requested to refrain from such language in future.[166] At this time, there were around 1,200 patients in the infirmary, cared for by three resident officers and one visiting physician.

The final enquiry arose after an outbreak of puerperal fever in the lying-in wards in April 1885. Simpson's re-organisation to transfer the accommodation to the female infirmary and later to the infectious wards, because of a further outbreak, was approved by the guardians. As the infectious wards were small, the guardians re-opened the girls' school as lying-in wards on 30 October.[167] Elizabeth Wood, aged 31 years, was admitted to the lying-in wards in the girls' school on 12 November and, later that day, was delivered of twin boys by nurse Rebecca Williams, after a labour lasting three hours and ten minutes (Appendix D). She had a two-year history of pulmonary tuberculosis. Her temperature was higher than normal on admission, but increased markedly after four days and remained at this level until her death on 6 December.[168] Simpson was of the opinion that she was not suffering from puerperal fever, although the two AMOs were not in agreement.[169] He requested a second opinion from Dr Edward Malins, Obstetric Physician to the General Hospital and Vice-President of the Obstetric Society of London, who confirmed the diagnosis of 'puerperal septicaemia', whose origin was intrinsic to the patient, but which was

[166] BCL, VGPC, GP/B/2/8/1/9, 5 December 1884.
[167] BCL, Infirmary Sub Committee (hereafter ISC), GP/B/2/4/1/2, 16 October 1885; BPP, 1886 (19-Sess. 2), pp.3-11.
[168] BPP, 1886 (19-Sess.2), pp.3-11, 24, 27, 29, 31; her initial temperature was 37.8º Centigrade, as opposed to the normal upper limit of 36.8ºC, and increased to 39.4ºC and then to 39.8ºC.
[169] The raised temperature at the start of the illness was not in keeping with a diagnosis of puerperal fever, although the increase after a few days would suggest the onset of septicaemia (see Appendix D).

communicable to other lying-in patients.[170] When the lying-in wards were moved to the girls' school, the members of the Infirmary Sub-committee were concerned that no-one involved in the wards up to that date should have any further attendance on lying-in patients. This included Simpson and they resolved that Henry Cook, one of the AMOs, should have sole charge of these wards. Simpson was informed of this on his return from a four-day stay in Ireland on 3 November. However, he continued to examine patients in the lying-in wards, including Elizabeth Wood, and perform deliveries until Malins confirmed Wood's diagnosis.[171]

The guardians referred the matter of Simpson's conduct to the LGB, with a request that the enquiry would be limited to whether he had disobeyed orders.[172] At the enquiry, Mr Price, chairman of the Infirmary Sub-committee, stated that he had informed Cook on 30 October that he was in 'sole charge' of the lying-in wards and, three days later, told Simpson of Cook's position and that the guardians wished to release him (Simpson) from attending cases in the girls' school. Both Cook and Simpson denied that Price had said Cook was to have 'sole and entire' charge. In addition, Simpson denied that Price had forbade him to enter the wards, and pointed out that he had not received any written confirmation of such an order. While the members of the enquiry, J. J. Henley and Dr F. Mouat, criticised the guardians for not making the order explicit and for failing to ensure all officers concerned were aware of it, they took the view that 'in charge' implied complete professional control as the only MO. They concluded that Simpson had disobeyed an important order and failed to justify his disobedience; the guardians were justified in their opinion that he had forfeited their confidence; and the Birmingham board should request his

[170] BCL, ISC, GP/B/2/4/1/2, 1 December 1885; BPP, 1886 (19-Sess. 2), p.24.
[171] BPP, 1886 (19-Sess. 2), pp.3-11.
[172] BCL, ISC, GP/B/2/4/1/2, 22 January 1886.

resignation.[173] However, he refused to do so, protesting to the LGB that there was no evidence that Price informed him not to attend the lying-in wards. He received support for his retention from the Medical Defence Union, local newspapers and some of the Birmingham guardians. At a special meeting of the Birmingham board on 15 June, there were sufficient guardians present who wished Simpson to be removed from office, to confirm his dismissal, despite strong support from some of the others.[174] The previous enquiries into Simpson's conduct were taken into consideration by the LGB when it refused to alter its decision.[175] In light of Simpson's continued refusal to resign, the LGB declared him 'unfit for the office of Medical Officer' and ordered him to cease to perform the duties of the office. He left the workhouse on 3 September 1886.[176]

It is obvious from the records that Simpson engendered strong feelings both toward and against him among the guardians and other officers, creating tension within working relationships in the workhouse. The matron, in 1877, was overheard to say he was not fit to be MO and, if he had been in Liverpool, would have been quickly dismissed. However, she and her husband, the master, were under investigation at that time and resigned before it could be concluded.[177] Price claims that, as a council member of the Poor Law Medical Officers Association, Simpson was a reforming poor law surgeon, but there is no evidence for this in the local records, in which he appears to have carried out his duties as required and no more. Likewise, Price's opinion that he repeatedly asked for more staff is not borne out in the guardians'

[173] BPP, 1886 (19-Sess. 2), pp.3-11.
[174] *Birmingham Daily Post*, 16 June 1886.
[175] BCL, BBG, GP/B/2/1/54, 4 August 1886.
[176] BCL, LGB Orders, GP/B/1/1/4, 2 August 1886; Incident Book, GP/B (Acc 2009/109), Box 15.
[177] BCL, Workhouse Inquiry Sub-committee (hereafter WISC), GP/B/2/3/11/1, 15 November 1877.

minute books, in which there is not one instance of him complaining of overwork.[178] Although he did admit to finding the work stressful, he denied that he found it particularly difficult to perform his duties before the AMO was appointed. In addition, he did not concur with the guardian who suggested that patients had suffered as a result of his workload.[179] He ought to have been aware of the possibility of the transmission of puerperal infection and sought clarification of his position, when, as he claimed, he was not given precise verbal instructions. In not doing so, perhaps he was the architect of his own downfall. It is also interesting to note that his professional conduct seems to have been less satisfactory after he had medical help, rather than during the period when he was on his own and suffered ill health. Nor was he in the vanguard of nursing reform. When the guardians asked his opinion on the appointment of a trained nursing superintendent, he replied that a professional nurse was not necessary, only 'a clever woman'.[180]

Summary

This study confirms the heavy and increasing workload of the WMOs. Although this caused some to resign or to request medical help, others merely used it as a tool to increase their salaries. By doing so, part-time MOs could employ their own assistants, and it is surprising that some full-time officers were content with extra payment only. An example is Edmund Robinson in Birmingham, who denied he needed assistance, despite the presence of between 600 and 700 sick inmates on his wards. He subsequently became one of the most highly paid poor law MOs (Table

[178] Price, 'Quantitative and qualitative study', pp.300, 315-17.
[179] BCL, WISC, GP/B/2/3/11/1, 24 January 1878.
[180] BCL, WISC, GP/B/2/3/11/1, 24 January, 22 March 1878.

4.1).[181] There is a marked difference between the employment of resident MOs in Birmingham, supported at times by visiting medical personnel, and the single part-time doctor in Wolverhampton. Part-time officers offered more continuity of care as they served for longer periods, but difficulties could arise if they suffered poor health or as they aged. As Birmingham's resident officers could spend most of the day and evening on the wards and be called during the night at times, it is difficult to imagine that Wolverhampton's officers could be providing adequate care with a visit of a few hours each day, even with a smaller number of sick inmates. Birmingham's medical staffing levels were exemplary in the early years of the NPL, but as the central authority imposed its rules governing medical duties, the reduction to one resident MO was highly unsatisfactory. To give some credit to the LGB, it was at their insistence that the number of MOs was increased and the new infirmary built. However, as the result of the infirmary being separately managed from the workhouse, medical cover in the latter was again reduced to one lone officer. The changes to the medical arrangements in Birmingham after the NPL resulted in the MOs losing the right to admit urgent cases directly to the infirmary without the permission of the guardians or an overseer and so imposed more completely the principle of less-eligibility. Nevertheless, it has been possible to draw out the characters of these previously unknown MOs, but not do likewise for the guardians, as their opinions are rarely identified as pertaining to named individuals.

One issue that has resulted from the WMOs heavy workload has been that of conflict with the guardians and resultant charges of medical negligence. Examination of Simpson's dismissal brings to the fore the role played by poor communication, a

[181] Price, 'Quantitative and qualitative study', p.224, has calculated that only 0.4% of poor law medical officers received more than £300 annually throughout the nineteenth century; BPP, 1867-68 (4), p.45.

factor which continues to be one of the most important in current medical complaints made by patients against doctors.[182] In Linda Mulcahy's study of patients' complaints in the late 1990s, the lowest incidence was in those medical specialties in which the patient was least empowered and of low social status.[183] As the main objective of the NPL was the disempowerment of indoor paupers, it might be expected that they would not feel able to question a doctor's practice. This study has demonstrated there were times when inmates complained about the treatment they received. On at least one occasion, it concerned the MO's attitude during examination (by Mary Shaw in Wolverhampton in 1855), the second commonest type of complaint in Mulcahy's study.[184] In the case brought against Simpson, both his and Cook's version of their conversation with Price was at variance with his and that of the master and nursing staff. Also the chairman of the board of guardians was not aware of the ruling to exclude Simpson from the lying-in wards. Poor communication was also an essential element in the incident of Galbraith and Buck, the tramp, in Wolverhampton. The majority of the other charges related to non-attendance at the workhouse and were not exclusive to non-resident officers. However, part-time officers in Wolverhampton were particularly guilty of this offence, although it was associated with ill health on more than one occasion. A low salary may have played a part in the frequency of attendance in the case of Cooper, but the others were paid an amount that was in the top 10% of the salary range throughout the nineteenth century.[185] In Wolverhampton, however, the two WMOs who died in office were middle-aged. In addition, the fact

[182] P. Bark, C. Vincent, A. Jones and J. Savory, 'Clinical complaints: a means of improving quality of care', *Quality in Health Care*, 3 (1994), p.125; P. Kinnersley and A. Edwards, 'Complaints against doctors', *British Medical Journal*, 336 (2008), p.841; L. Mulcahy, *Disputing Doctors: the socio-legal dynamics of complaints about medical care*, Maidenhead, 2003, pp.45, 68-69.
[183] Mulcahy, pp.68-69. The majority of cases of complaints quoted by Klein against general practitioners between 1949 and 1971 concerned children and older adults, Klein, pp.37-57.
[184] Mulcahy, pp.68-69.
[185] Price, 'Quantitative and qualitative study', p.224.

that most charges took place before the onset of the crusade against outdoor relief is at variance with the national picture.[186] MOs were often exonerated or given a caution when charges related to subjecting patients to degrading treatment, as in the matter of Cooper's handling of children in Wolverhampton. Crowther has commented that guardians were prepared to defend an MO, whatever the charge, if they were subservient to the guardians' standards.[187] Whether subservience to the guardians had an influence on the medical treatment that WMOs prescribed for sick inmates will be discussed in the next chapter.

[186] Ibid., p.189.
[187] Crowther, 'Paupers or Patients?', p.40.

CHAPTER 5

MEDICAL AND SURGICAL TREATMENT OF PATIENTS

'the Sick Inmates…are fully treated up to the scientific attainments of the present day.'[1]

The nature of medical care in workhouses after the New Poor Law (hereafter NPL) and of the clinical treatment inmates received, as well as how representative it was of nineteenth-century therapeutics is not well understood.[2] This chapter analyses the therapies that medical officers (hereafter MOs) utilised in the management of patients in Birmingham and Wolverhampton workhouses and attempts to reconstruct the treatments they prescribed. Because workhouse medical officers (hereafter WMOs) were often required by boards of guardians to pay for the drugs they used from their salaries, historians have accused them of withholding effective treatment. Joseph Rogers recounts that, when he was appointed MO to Westminster workhouse in 1872, the retiring physician expressed pride in the fact that the only medicine he gave inmates was peppermint water.[3] Was this true of other workhouses, or just an unrepresentative anecdote? At the beginning of the nineteenth century, medical treatment was much as it had been for many centuries, with the emphasis on depletive therapies, and it was not until the end of the century that the production of effective

[1] Birmingham Central Library (hereafter BCL), Infirmary Sub Committee (hereafter ISC), GP/B/2/4/1/4, 25 November 1887.
[2] S. King, 'Poverty, Medicine and the Workhouse in the Eighteenth and Nineteenth Centuries', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse*, Rochester, 2013, pp.229, 234-35.
[3] Rogers (ed.), *Reminiscences of a Workhouse Medical Officer*, London, 1889, pp.111-12.

treatments, in the form of the first vaccines for infectious diseases took place.[4] However, from the perspective of twentieth-century pharmacology, the only really effective drugs were opium and aperients, and the only one that could cure disease was, arguably, quinine for malaria.[5] One advance in therapeutic technique was the introduction of the hypodermic syringe for subcutaneous administration of drugs by Edinburgh physician Alexander Wood in 1855.[6] Historians agree that nineteenth-century medical therapeutics worked in the context of the culture of the time and that patients had visible evidence of the effectiveness of the regimens employed.[7]

Four approaches will be used to uncover therapeutic practice in the workhouses. First, therapies, such as natural and physical medical treatments, the use of food and alcohol as treatment for disease and the drugs prescribed, will be described. Alcohol was an important and widely used therapy in the nineteenth century, but its prescription in workhouse infirmaries has not previously been investigated. An alternative approach to aid the understanding of therapeutic practice will investigate the management of specific conditions, such as respiratory disease, venereal disease and epilepsy. Third, the management of individual patients and their perspective on the treatment they received will be addressed through the complaints they made to the guardians. Finally, an exploration of surgical practice will trace the increasing number and the nature of operations within the workhouses. The chapter will also

[4] J. H. Warner, *Therapeutic Perspective*: *Medical Practice, Knowledge, and Identity in America, 1820-1885*, Cambridge, Massachusetts, 1986, p.1; C. E. Rosenberg, 'The Therapeutic Revolution: Medicine, Meaning, and Social Change in Nineteenth-Century America', *Perspectives in Biology and Medicine*, 26 (1977), p.485.
[5] N. M. Goodman, 'Medical Attendance on Royalty', in F. N. C. Poynter (ed.), *Medicine and Science in the 1860s*, London, 1968, p.134; W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, Cambridge, 1994, p.223.
[6] K. D. Keele, 'Clinical Medicine in the 1860s' in F. N. C. Poynter (ed.), *Medicine and Science in the 1860s*, London, 1968, p.9.
[7] Rosenberg, pp.485-86.

address the question of the extent to which guardians limited the treatments that inmates could receive and over-ruled medical officers' prescriptions and advice.

Therapeutic Principles

Before considering individual treatments, it is necessary to understand the principles on which they were prescribed. The antiphlogistic, depletive regimen of the eighteenth century remained the mainstay of medical treatment at the beginning of the nineteenth. Bloodletting, purgation, a debilitating diet, sedating drugs and bed-rest were employed to relax the state of excitement that was thought to be induced in the body by disease. However, by the middle of the eighteenth century, a stimulant regimen was also used when the physician considered the illness was producing a debilitating state in the patient. One of the major proponents of this system was the Edinburgh physician, John Brown (1735-88), who postulated that all diseases were due to an excess or deficiency of natural energy or 'excitability'.[8] The condition with excess, he called *sthenia*, while deficiency resulted in *asthenic* disease. He did not believe in the healing power of nature to overcome disease, but considered all maladies required a stimulant. *Sthenic* conditions required antiphlogistic regimens of bloodletting, purging, cold applications and physical rest, which were all weak stimulants to reduce excessive excitement. Strong stimulants were required to increase deficient excitement in *asthenic* conditions and these included wine or spirits, gentle exercise, increased mental activity and the drugs, opium, camphor, musk and ether. The choice of stimulant for any individual patient depended on the speed of

[8] G. B. Risse, 'Brunonian Therapeutics: New Wine in Old Bottles?', *Medical History*, Supplement No. 8 (1988), p.48.

action and level of stimulation required.[9] Brunonian therapeutics were not taken up enthusiastically in Britain, because judging the degree of bodily excitability and distinguishing *asthenia* from *sthenia* were problematic. Nevertheless, the importance of his theory lay in providing an alternative form of therapy to the exhausting eighteenth-century medical treatments of purging and diuresis.[10] The other components of the stimulant regimen were a fuller diet containing meat, hot-baths rather than cold, exercise, alcohol and tonics. However, whichever regimen was chosen depended on the physician's judgement as to the effect of the disease on the patient. On some occasions, an initial depletive regimen would be replaced by a more stimulating one as the patient's condition improved.[11]

Natural and Physical Therapies

Medical practitioners employed therapies utilising the natural environment to aid the body's natural healing process or to combat the spread of disease as understood at the time. One of the more important environmental measures in institutions was efficient ventilation and the duties of the workhouse medical officer included advising on the adequacy of ventilation and sanitary arrangements. The miasma theory of disease dates back to around the sixth century and has been termed one of the earliest of the more 'scientific' theories of the spread of infection.[12] According to this theory, disease could arise spontaneously in rotting matter, human waste and stagnant water

[9] Ibid.
[10] D. Hamilton, *The Healers*: *A history of medicine in Scotland*, Edinburgh, 1981, p.138.
[11] G. B. Risse, *Hospital Life in Enlightenment Scotland: Care and Teaching at the Royal Infirmary of Edinburgh,* Cambridge, 1986, p.181.
[12] G. A. J. Ayliffe and M. P. English, *Hospital Infection: From Miasma to MRSA*, Cambridge, 2003, p.2.

and was spread in the emanations given off into the atmosphere from these sources.[13] Many physicians continued to cling tenaciously to this mode of disease transmission late in the nineteenth century. It followed that, to combat cross-infection in hospitals and infirmaries, adequate ventilation was required and the pavilion system of building these institutions was devised to ensure this. Although wards with windows placed opposite to each other were first suggested in *An Essay on Parish Workhouses* in 1867 by Gillingwater, it was not adopted generally until the Poor Law Board (hereafter PLB) issued a circular a century later stating that all new infirmaries must adopt the pavilion principles.[14] These involved long wards with opposing windows, built in separate blocks. A few years before this circular, Edmund Robinson, WMO in Birmingham, suggested that new infectious disease wards should be built so that the walls with the windows would not be restricted by other buildings, so enabling as much fresh air as possible.[15] Both the new Birmingham infirmary in 1889 and the new Wolverhampton workhouse in 1903 were erected according to the pavilion plan.

Robinson, like many of his contemporaries, held a strong belief in the curative power of fresh air: 'Pure air is the very life and blood, so to speak, of the sick and without it, the most consummate skill in medical or surgical treatment is of little or no avail'.[16] However, twenty years before Charles Smith, house surgeon at the infirmary, cautioned against the excessive use of fresh air in the sick wards in the winter as the patients suffered mainly from 'pulmonary, bronchial, rheumatic affections'. He pointed out that the result would be an exacerbation of pain in those with rheumatism

[13] G. Rosen, *A History of Public Health*, New York, 1958, p.288; C. F. Brockington, *A Short History of Public Health*, London, 1966, p.40.
[14] K. Morrison, *The Workhouse, A Study of Poor-Law Buildings in England*, Swindon, 1999, pp.20, 105.
[15] BCL, Visiting and General Purposes Committee (hereafter VGPC), GP/B/2/8/1/4, 17 June 1864.
[16] Ibid., 17 June 1864.

and coughing and dyspnoea in those with lung conditions. He emphasised that these patients were susceptible to sudden changes of temperature, which could worsen their condition.[17] The therapeutic benefit of fresh air was one of the basic principles behind open-air treatment for tuberculosis.[18] However, at the beginning of the twentieth century, the quality of the air in Birmingham was felt to be too impure to treat inmates suffering from tuberculosis by the open-air method, as the infirmary was by then surrounded by many factories contaminating the atmosphere.[19] Around this time, Arthur Foxwell, physician to the Queen's Hospital, introduced an open-air ward on the top floor of the building, but it was used for the treatment of non-tuberculous patients.[20]

The medicinal use of water dates back as far as ancient Greece, when water was thought to both stimulate and tranquillize the nervous system and its healing properties could restore harmony to bodily humours.[21] The therapeutic benefit of cold baths were promoted in England by Sir John Floyer, an eminent physician from Lichfield, in his 1702 treatise on the use of hot and cold baths.[22] In the early nineteenth century, Vincenz Priessnitz, an Austrian layman, developed a new system of treatment, of which the main tenets were that disease resulted from attempts by the body to expel foreign matter and only cold water, used internally and externally,

[17] BCL, House Committee (hereafter HC), GP/B/2/3/1/1, 7 February 1843.
[18] F. Condrau, 'Beyond the Total Institution: Towards a Reinterpretation of the Tuberculosis Sanatorium', in F. Condrau and M. Worboys (eds), *Tuberculosis Then and Now*, Montreal, 2010, pp.80-81; a discussion of the nature of this treatment appears in chapter 3.
[19] BCL, Workhouse Infirmary Management Committee (hereafter WIMC), GP/B/2/4/4/5, 9 March 1908.
[20] J. Reinarz, *Health Care in Birmingham: The Birmingham Teaching Hospitals 1779-1939*, Woodbridge, 2009, p.151.
[21] R. Price, 'Hydropathy in England 1840-1870', *Medical History*, 25 (1981), p.270; R. Jackson, 'Waters and Spas in the Classical World' in R. Porter (ed.), 'The Medical History of Waters and Spas', *Medical History* Supplement, 10 (1990), p.1.
[22] Ibid., p.271; F. D. Zeman, 'Life's Later Years', in G. J. Gruman (ed.), *Roots of Modern Gerontology and Geriatrics*, New York, 1979, p.941.

could separate and remove it. His water cure became extremely popular and was brought to England in 1842 by Dr James Wilson.[23] However, therapeutic bathing had been in use in hospitals prior to that time; for instance, just over 115 of patients in the Royal Infirmary of Edinburgh received some form of bathing as part of their treatment in the last quarter of the eighteenth century.[24] The hospital provided separate hot and cold baths for patients' use only, although they could also use portable tubs in the wards. Baths were thought to exert a tonic effect on the nervous system, to be useful in skin conditions, and the relaxing effect of a warm bath for fifteen to twenty minutes was used to help patients with chronic rheumatism and post-paralytic muscular contractions.[25] Vapour baths were in use in Birmingham Skin Hospital to treat a variety of dermatological diseases in 1882.[26] Richard Nugent, MO at Wolverhampton workhouse, prescribed three warm baths per week for children with skin disease in 1858. Four boys and 30 girls over the age of two years were suffering from 'impetigo', which he put down to poor personal cleanliness and inadequate ventilation in the building.[27] More than three decades later, Edward Watts, WMO at the time, was using large quantities of mineral water in the treatment of patients. One of the guardians, Dr Totherill, a hospital physician, considered it an ineffective therapy, but could not persuade Watts to discontinue its use. Totherill accepted that Watts had the authority to order it and the guardians were powerless to over-rule him.[28] The MO in Birmingham workhouse also used Buxton water to treat a patient in 1855 with good effect.[29] The Victorian period witnessed a profusion of

[23] Price, pp.271-73; H. Marland and J. Adams, 'Hydropathy at Home: The Water Cure and Domestic Healing in Mid-nineteenth-century Britain', *Bulletin of the History of Medicine*, 83 (2009), pp.500-1.
[24] Risse, *Hospital Life*, p.203.
[25] Ibid., p.211.
[26] Reinarz, *Health Care in Birmingham*, p.110.
[27] Wolverhampton Archives and Local Studies (hereafter WALS), Wolverhampton Board of Guardians (hereafter WBG), PU/WOL/A/10, 13 August 1858.
[28] WALS, *Wolverhampton Chronicle* (hereafter *WC*), 14 June 1893.
[29] BCL, VGPC, GP/B/2/8/1/1, 24 August 1855.

spas and mineral water hospitals, which specialised in the treatment of chronic rheumatic diseases.[30] Birmingham guardians utilised such facilities for Thomas Regan, a young inmate suffering from chronic gout, by arranging his attendance at Droitwich Salt Baths in 1883.[31]

While water was thought to strengthen the body, bloodletting weakened the body as it affected a cure.[32] The rationale behind its use was based on the causation of disease by the imbalance of humours. At the time of the Roman Empire, Galen had postulated that certain diseases, such as fevers, resulted in a build-up of blood or 'plethora' and could be corrected by bloodletting. Despite advances in the understanding of human physiology from the seventeenth century onwards, it remained the mainstay of the antiphlogistic regimen. In the late eighteenth century, 25% of patients in the Royal Infirmary of Edinburgh were subjected to one or other forms of bleeding, despite a degree of popularity for John Brown's stimulant treatment after 1780.[33] In the early nineteenth century, the medical system proposed by François-Joseph-Victor Broussais, renowned as the leader of Paris medicine at the time and acclaimed as the inventor of 'physiological medicine', resulted in resurgence in the use of therapeutic bleeding.[34] He considered that all diseases were due to over stimulation of bodily function resulting in local inflammation, most frequently in the stomach, but which could spread throughout the body. Thus, the appropriate treatment for all disease was an antiphlogistic regimen of a debilitating diet and

[30] D. Cantor, 'The Contradictions of Specialization: Rheumatism and the Decline of the Spa in Inter-war Britain' in R. Porter (ed.), 'The Medical History of Waters and Spas', *Medical History* Supplement, 10 (1990), p.127.
[31] BCL, ISC, GP/B/2/4/1/1, 20 April 1883.
[32] Marland and Adams, p.506.
[33] Risse, *Hospital Life*, p.203.
[34] E. H. Ackerknecht, *Medicine at the Paris Hospital 1794-1848*, Baltimore, 1967, p.61.

bloodletting by means of locally applied leeches.[35] The practice of removing blood from the body declined substantially after the 'blood-letting controversy' in Edinburgh in 1857, in which John Bennett, professor of the institutes of medicine, challenged the principles behind the bleeding of patients.[36] However, its value as treatment continued to be accepted theoretically. For instance, all methods were reduced from 35% of patients in Massachusetts General Hospital in the 1830s to only 1% in the 1880s.[37]

The most common method of general bloodletting was by venesection, the opening of a vein using a lancet. It produced a reduction in pulse rate, a decrease in body temperature and a feeling of relaxation, considered necessary in *sthenic* conditions. If local extraction of blood was required, for instance from an inflamed joint or around the eyes in ophthalmia, leeches were used. Leeches had been in use in medical practice in ancient Greece and the species preferred for this purpose was named *Hirudo medicinalis* by Linnaeus in 1758.[38] It took from 30 to 60 minutes for the worm to extract sufficient blood to drop off the skin, but bleeding can continue from the site for up to one hour, as the leech produces an anticoagulant transmitted to the host via its mouth.[39] Leech therapy gained great popularity in the early nineteenth century, as Broussais promoted it as his preferred method of bloodletting. However, its use continued unabated after Broussais' theories were discredited.[40] Local bloodletting could also be carried out by cupping, using vessels attached to the skin to

[35] Ibid., pp.61-71; Warner, *Therapeutic Perspective*, pp.48-50.
[36] J. H. Warner, 'Therapeutic Explanation and the Edinburgh Bloodletting Controversy: Two Perspectives on the Medical Meaning of Science in the Mid-nineteenth Century', 24 (1980), pp.241-42, 254.
[37] Warner, *Therapeutic Perspective*, p.117.
[38] R. G. W. Kirk and N. Pemberton, *Leech*, London, 2013, pp.49, 62.
[39] Ibid., pp.51, 160-63.
[40] Ibid., pp.55, 59; Acknerknecht, p.70.

induce a partial vacuum, and by blistering or applying plasters containing irritative substances to the skin. There is no record of venesection being used in either Birmingham or Wolverhampton workhouse, but Birmingham guardians spent between £11 and £24 per quarter on the purchase of leeches between 1847 and 1849.[41] At that time, Mary Hill was employed in the workhouse as the 'Leech Woman in Surgery' and earlier in the decade, two male inmates were paid 1s each *per* week as 'leech bleeder[s]'.[42] The guardians agreed that leeches could be supplied from the infirmary to treat the sick poor at home on the instruction of the district surgeons.[43] In 1868, Edmund Robinson, WMO in Birmingham, requested leave to have treatment for 'inflammation' of his eyes by the production of blisters.[44]

The other common physical therapy was carried out using static electricity. The greater understanding of the principles of electricity in the early eighteenth century led to its promotion as a medical treatment. Within two decades, it had become 'the fashionable wonder of mid-Georgian England'.[45] Machines generating static electricity, such as the Leyden jar, were developed and used to deliver both a generalised electrical stimulation to the body and localised 'shocks' to specific areas.[46] Around 5% of patients in the Royal Infirmary of Edinburgh in the late eighteenth century received electrical therapy, mainly for paralysis and rheumatism.[47] An electrical machine was one of the first pieces of medical equipment purchased at

[41] BCL, Birmingham Board of Guardians (hereafter BBG), GP/B/2/1/5, 4 January, 25 May 1848; GP/B/2/1/6, 24 April, 22 May 1849.
[42] BCL, BBG, GP/B/2/1/5, 13 March 1846; BCL, HC, GP/B/2/3/1/1, 9 August 1842; see Table 6.6.
[43] BCL, BBG, GP/B/2/1/4, 1 December 1841.
[44] BCL, VGPC, GP/B/2/8/1/5, 24 July 1868.
[45] P. Elliot, '"More Subtle than the Electric Aura": Georgian Medical Electricity, the Spirit of Animation and the Development of Erasmus Darwin's Psychophysiology', *Medical History*, 52 (2008), p.198.
[46] Risse, *Hospital Life*, p.216.
[47] Ibid. pp.203, 217.

the Birmingham General Hospital after it opened in 1779.[48] Electrotherapeutics became more widely used from the 1830s, reached its height of popularity in the 1890s, but fell into relative disuse from the 1910s.[49] Local application of an electric current through a particular part of the body was preferred, avoiding the occurrence of an electric shock or the production of pain.[50] Electrical therapy was used to treat a variety of chronic diseases, but more specifically neurological conditions such as paralysis and chorea.[51] Because it was thought also to be able to influence internal organs, it was preferred instead of surgery for gynaecological conditions.[52] The electric current applied to the patient could be generated by an induction coil (faradic electricity) or by a battery (galvanic electricity).[53] An 'Electro Galvanic Battery' was purchased by Birmingham guardians in 1850 for use by the WMO, John Humphrey. In his successful request for the purchase of an additional battery for the machine, he praised the 'beneficial effect' it had on patients.[54]

Nutrition

Diet was considered to be an important item in the therapeutic regimen because of its ability to provide a stimulus to the human system.[55] As a result, different types of diet were prescribed for specific indications and medical institutions incorporated them

[48] Reinarz, *The Birth of a Provincial Hospital*, p.28.
[49] Elliott, p.219; L. Rosner, 'The Professional Context of Electrotherapeutics', *Journal of the History of Medicine and Allied Sciences*, 43 (1988), pp.67, 78; I. R. Morus, *Shocking Bodies*, Stroud, 2011, pp.81-83.
[50] Rosner, pp.64, 70; Morus, p.126.
[51] Morus, pp.84, 126.
[52] Rosner, pp.72-73.
[53] Ibid., p.64.
[54] BCL, BBG, GP/B/2/1/7, 19 June 1850; GP/B/2/1/8, 30 October 1850; the term galvanic derived from Luigi Galvani, an Italian physician, who carried out experiments in which he stimulated frogs' legs with electricity.
[55] Risse, *Hospital Life*, p.221.

into their official regulations. The aim was to manage a patient's diet in order to allow the healing process to proceed unhindered. In the 1860s, German chemist Justus von Liebig, who had a seminal influence on nineteenth-century chemistry by applying it to the functioning of living organisms, put forward his principles of nutritional physiology.[56] He divided food into those components, such as protein, that were converted into organised tissue and those, such as carbohydrate and fat, which were oxidised to assist respiration and provide heat.[57] He postulated that a 'vital force' caused the decomposition of food and its assimilation into the tissues of the body and also provided resistance to destructive influences.[58] He explained the cause of disease as an inability of the 'vital force' to neutralise all disturbing factors. Oxygen was the principal instrument causing disease, because of its ability to destroy living tissue, but certain foods could minimise tissue breakdown.[59]

Doctors in institutions organised a series of dietaries for different conditions: regular, full, low, fever, ordinary sick. A low debilitating diet was an essential ingredient for the antiphlogistic or sedative regimen. It was lacking in animal food products other than milk, given in small quantities and prescribed for all inflammatory conditions.[60] As the century progressed and the theories of disease altered, so the therapeutic manipulation of the diet led to the increasing use of stimulant regimens, similar to those proposed by John Brown almost a century before. John Warner has shown that the low diet declined in use, from 16% of patients at Massachusetts General Hospital in the 1830s to 2% in the 1870s. Prescription of a high diet underwent the reverse

[56] W. H. Brock, 'Liebigiana: Old and New Perspectives', *History of* Science, xix (1981), p.201; T. O. Lipman, 'Vitalism and Reductionism in Liebig's Thought', *Isis*, 58 (1967), p.185.
[57] Warner, 'Physiological Theory and Therapeutic Explanation in the 1860s: The British Debate on the Medical Use of Alcohol', *Bulletin of the History of Medicine*, 54 (1980), pp.241-42.
[58] Lipman, pp.179-80.
[59] Ibid., p.180.
[60] Risse, pp.220-24; Warner, *Therapeutic Perspective*, pp.145-46.

process, from nil in the earlier period to 20% in the later one.[61] The main ingredients in the strengthening diet were beef, mutton or chicken as meat was considered a powerful stimulant.[62]

Dr Edward Smith, MO of the PLB, reported on 'Dietaries for the Inmates of Workhouses' in 1866, with recommended dietaries for different classes of inmate. However, these did not include guidance for sick inmates as their diet was under the control of the medical officers, who adapted them to the individual needs of each patient. He did note the variability in the ordering of medical extras, from a wide variety in some workhouses to almost nothing in others. Arrangements for set dietaries for the sick, which could be adjusted as necessary, were advised for the convenience of food preparation; and he gave examples of such diets in use in 68 workhouses he had surveyed.[63] The main constituents of the 'Full Diet' for sick inmates were bread, butter and tea for breakfast and supper; meat, potatoes, and bread at dinner. Named dietaries included low, extra, milk, special, liquid, convalescent, while some unions only labelled them by numbers. The majority of unions provided three or four sick diets, although each diet was also available with a lower quantity of food for women.[64] Fifteen unions had no set dietaries, leaving the medical officer to order individual diet, and of those unions that did have them, 74% provided specific fever diets.[65] The sick dietaries in Cardiff Workhouse in the 1880s similarly relied mainly on bread, cooked meat, potatoes and soup. The fever diet, consisting of eight ounces of bread and two and one-eighth pints of milk with beef tea when required,

[61] Warner, *Therapeutic Perspective*, p.117.
[62] Risse, *Hospital Life*, p.222.
[63] British Parliamentary Papers (hereafter BPP), 1866 [3660], pp. 20, 54-55.
[64] Ibid., pp.232-81.
[65] Ibid.

was prescribed to all acute cases as well as to patients with fever.[66] The 'Full Sick' dietary in Birmingham workhouse in the early years after the NPL contained bread, milk pottage, cooked meat, potatoes, soup, cheese and suet puddings. For those who could not manage the quantity involved in the full diet, there was the 'Half Sick' diet, which was smaller in quantity, with similar ingredients except for the meat, which was unsalted.[67] Birmingham guardians sought permission from the Local Government Board (hereafter LGB) in 1886 as their medical officers wished to make a fish diet available for patients. This was made up of 10 ounces of bread daily, with a half pint of milk for breakfast, 8 ounces of boiled fish and half a pound of potatoes for dinner, and one pint of gruel for supper. Presumably, the intention was to use it to treat certain conditions, as Dr Suckling was of the opinion that there were about 25 patients under his care in the infirmary who would benefit from it. The LGB pointed out that 'dietaries' for sick inmates were at the sole discretion of MOs and did not require the Board's approval.[68] When it issued new regulations for dietaries for different classes of inmate at the beginning of the twentieth century, infirm men and women were included, with reduced amounts for those whom the MO considered could not take the full ration.[69] The nutritional content of these diets must be questioned, however, as an outbreak of scurvy occurred in the mental wards of Wolverhampton workhouse in January 1908.[70] However, no recommendation was made for inmates with an acute illness. Consequently, minutes of the guardians in Wolverhampton and Birmingham contain little information on the diets prescribed for sick inmates.

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[66] Sheen, *The Workhouse and its Medical Officer*, Bristol, 1890, pp.17-18, 61.
[67] BCL, BBG, GP/B/2/1/4, 17 October, 9 December 1838; HC, GP/B/2/3/1/1, 14 November 1844.
[68] The National Archives (hereafter TNA), MH12/13353, 17 May 1886.
[69] BCL, Workhouse Management Committee (hereafter WMC), GP/B/2/3/2/3, 7 December 1900; WALS, HC, PU/WOL/E/1, 25 January 1901.
[70] WALS, House Committee (hereafter HC), PU/WOL/E/3, 9 January 1908; scurvy results from a dietary deficiency of vitamin C.

Medicinal Use of Alcohol

Alcohol, especially in the form of wine, was an important therapeutic agent in the treatment of the sick, used externally as an antiseptic on wounds and burns, internally before and after surgery as an analgesic and sedative and medically as an appetite stimulant and diuretic.[71] The prescription of wine reached its greatest medical popularity during a period from the seventeenth to nineteenth centuries, but its use declined in the late nineteenth century following doubts about its efficacy and the appearance of new pharmacological agents.[72] The initial stimulus in the later eighteenth century for the more widespread use of alcohol, providing it with a rational basis for its prescription, was the system of medicine proposed by John Brown in the previous century. According to W. F. Bynum, alcoholic beverages along with opium were Brown's favoured remedies for *asthenic* conditions.[73] Alcohol was a popular remedy among Brown's colleagues and his esteemed mentor, William Cullen, prescribed beer liberally in fever cases.[74] The increasing cost of the consumption of alcoholic-containing drinks in the 1790s forced the Royal Infirmary of Edinburgh to tighten its procedures for their prescription, by requiring the physicians to record them each day.[75]

By the middle of the nineteenth century, 'alcoholic therapeutics' had gained a prominent position in British medical practice, replacing the use of bloodletting and

[71] S. P. Lucia, *A History of Wine as Therapy*, Philadelphia, 1963, pp.110, 114,150; H. W. Paul, *Bacchic Medicine*: *wine and alcohol therapies from Napoleon to the French Paradox*, Amsterdam, 2001, pp.i, 60.
[72] Lucia, pp.8, 155-56; Paul, p.iii.
[73] Bynum, p.17.
[74] Risse, 'Therapeutics', pp.50, 61.
[75] Risse, *Hospital Life*, p.225.

purgatives. In the words of Warner, 'the brandy bottle replaced the lancet'.[76] A debate within the medical profession took place at that time over the pharmacological action of alcohol in disease, recorded in the pages of *The Lancet* and *British Medical Journal*. Physicians did not doubt that alcohol was an effective therapeutic agent, and used it as the stimulant of choice, but now required scientific validity of its mode of action. The therapeutic theories expounded included alcohol acting as a food and so being metabolised completely within the body; it being totally eliminated from the body unchanged and so having no nutritive value; and it being able to act as an antipyretic.[77] Samuel Wilks, physician to Guy's Hospital, suggested 'the most important question in therapeutics at the present day is the value of alcohol in disease'.[78] However, changing scientific views of the action of alcohol on the body had little influence on clinical practice.

Liebig classified alcohol with nutritional elements, but postulated that its greater capacity to become oxidised in the bloodstream meant it was more efficient in preventing tissue breakdown. Robert Todd, a physician at King's College London, used this concept to promote the scientific basis and theoretical justification for the medicinal use of alcohol. He believed that all disease resulted in depression of vital power and disintegration of tissue, secondary to inflammation. Alcohol could protect healthy tissue from being used to generate body heat, but it was also capable of directly stimulating the nervous system.[79] For Todd's theory to hold true, alcohol had to be completely metabolised within the body and this effect was disputed following experiments by Lallemand and colleagues in the late 1850s. Attention now turned to

[76] Warner, 'Physiological Theory', p.236.
[77] Ibid., p.235; an antipyretic has the ability to lower body temperature.
[78] S. Wilks, 'Indiscriminate Use of Alcohol Stimulants in Disease', *The Lancet*, i (1867), p.505.
[79] Paul, p.66; Warner, 'Physiological Theory', pp.240-42, 244.

the effect of alcohol on the body's temperature. Rather than raise body temperature by the production of heat as had previously been postulated, it was observed that ingested alcohol could have the opposite effect in a healthy individual. This led to its widespread use in high dosage in the treatment of fevers and, by the early 1870s, it had become the mainstay of treatment for typhus and typhoid.[80] The use of large doses of alcoholic stimulants in febrile illness was challenged by William Gairdner, professor of the practice of medicine at the University of Glasgow. In 1864, he reported a reduced mortality in typhus patients treated without alcohol and concluded that its use poisoned, rather than supported, the body.[81] Historian Harry Paul has acknowledged that, by the 1880s, alcohol no longer played a major role in the therapeutic discourse of medicine, although it continued to be prescribed widely as a therapeutic agent until the 1920s.[82] Wine was the commonest alcoholic beverage prescribed and its continued use could be justified as its many other constituents were thought to contribute to its therapeutic benefit.[83]

The majority of doctors recognised the harmful effects of alcohol on the body by the late nineteenth century, particularly cirrhosis of the liver, and were aware of the condition of alcoholism. This recognition and the influence of the growing impact of the temperance movement led to more moderate doses being used.[84] By 1830, local temperance societies were present in all major British cities.[85] Teetotallers strongly attacked the theories of alcohol's medicinal qualities and were supported by a few

[80] S. E. Williams, 'The Use of Beverage Alcohol as Medicine 1790-1860', *Journal of Studies in Alcohol*, 41 (1980), p.551; these infections were very prevalent in workhouses and typhus was often referred to as 'workhouse' fever; see chapter 3 for further details.
[81] W. T. Gairdner, 'Facts and Conclusions as to the Use of Alcoholic Stimulants in Typhus Fever', *The Lancet*, i (1864), pp.291-94.
[82] Paul, pp.92, 134; Warner, 'Physiological Theory', p.256.
[83] Paul, p.209.
[84] Paul, pp.167, 171, 308; J. Sournia, *A History of Alcoholism*, Oxford, 1990, p.70.
[85] Ibid., p.98.

medical men, such as Benjamin Ward Richardson, who later became a physician at the London Temperance Hospital.[86] Some influence on medical practice was achieved as practitioners subsequently limited their use of alcohol, although this occurred in the context of a reduction in the general consumption of spirits of 80% and of beer of 38% between 1831 and1931.[87]

Workhouse inmates were supplied with alcoholic beverages for a variety of reasons. Beer was provided in the dietary for able-bodied inmates in some workhouses, more often in the early years of the NPL. For instance, the ordinary dietary in Birmingham in 1834 included beer at dinner on five days each week and, four years later, it was increased to one pint of beer every day for both men and women. However, paupers in the infirmary were restricted to one half pint daily, but, six years later, beer had been withdrawn from those on the 'half sick' diet.[88] Patients in West Ham Union Infirmary were also given beer at dinner and supper, with those on the full diet allowed one and a half pints and on the half diet one pint, but patients on the low and fever diets were not permitted alcohol.[89] Voluntary hospital patients were also allowed regular alcoholic beverages; for instance, in the Royal Infirmary of Edinburgh in the eighteenth century, a 'house' beer of low alcoholic content of 1.2% was served during breakfast and supper.[90] Alcoholic beverages were frequently provided to inmates who carried out tasks within workhouses, including the pauper nurses. Edward Smith, MO to the PLB, in his report on Metropolitan Workhouses in

[86] Ibid., pp.298-99; J. Reinarz and R. Wynter, 'The Spirit of Medicine: The Use of Alcohol in Nineteenth-Century Medical Practice', in B. Schmidt-Haberkamp and S. Schmid (eds), *Drink in the Eighteenth and Nineteenth Centuries*, London, 2014, p.138.
[87] Lucia, pp.161-62; B. H. Harrison, *Drink and the Victorians: the Temperance Question in England, 1815-72*, Keele, Staffordshire, 1994, p.38.
[88] J. Lane, *A Social History of Medicine*: *Health, Healing and Disease in England, 1750-1950,* London, 2001, p.62; BCL, BBG, GP/B/2/1/4, 17 October 1838; HC, GP/B/2/3/1/1, 14 November 1844.
[89] R. G. Hodgkinson, *The Origin of the National Health Service: the Medical Services of the New Poor Law 1834-71,* London, 1967, p.154.
[90] Risse, *Hospital Life*, p.224.

1866, noted that paupers, in many workhouses, were given a daily allowance of either one pint or one and a half pints of strong porter, plus one or more glasses of gin for carrying out disagreeable work.[91]

MOs could prescribe alcohol on an individual basis, as part of 'medical extras' paid for by the guardians, for both pauper nurses and patients. As the majority of contracts held by MOs stipulated that they were required to pay for drugs they prescribed, guardians were suspicious that medical extras were frequently substituted for drugs in order to avoid this expense. Both they and the central authority strove continually to control the cost of alcohol consumption in workhouses, but this proved difficult due to alcohol's status as a medicine, although this was challenged in the latter part of the nineteenth century. Jonathan Reinarz and Rebecca Wynter assert that a decline in the prescription of alcohol in institutions had more to do with cost than a change in prevailing theories.[92] They give as an example the marked difference at the General Hospital in Birmingham between the years of 1865-1867 and 1881-1884, when the consumption rate of wine reduced from 0.09 to 0.02 bottles, spirits from 0.07 to 0.03 bottles, beer from 0.55 to 0.01 quarts, and ale from 0.58 to 0.09 quarts.[93] A similar situation with increasing costs leading to restrictions in the prescription of wine and beer at the Royal Infirmary of Edinburgh in the 1790s has already been mentioned.[94] At the time when alcoholic beverages were more freely prescribed at the General Hospital, Edward Smith considered that the quantities of 'spirituous liquors' ordered in provincial workhouses and 'the length of time' during which they are ordered, are 'sufficiently astonishing', and will, I do not doubt, ultimately engage the attention of

[91] BPP, 1866 (372), p.25.
[92] Reinarz and Wynter, pp.136-37.
[93] Ibid.
[94] Risse, '*Therapeutics'*, p.52.

the Poor Law Board'. [95] This issue was the only one he had encountered where there was widespread disagreement between the views of guardians and MOs. Smith's assumption proved correct and the first of a number of returns relating to the consumption of alcoholic beverages by paupers was issued in 1872.

The criticism by historians that WMOs ordered extras, including alcohol, to avoid the cost to themselves of prescribing drugs did not apply in Birmingham as the guardians continued to meet the cost of drugs ordered in the workhouse under the NPL, as they had previously. Wolverhampton guardians did not agree to pay for medicines until 1874, but before this time, there had been no concerns raised in Wolverhampton over the cost of extras, despite the consumption of alcoholic beverages rising significantly between 1842 and 1846, while the number of inmates stayed the same (Table 5.1).[96] Although the number of patients increased in 1843, it remained static thereafter and the increased consumption most likely reflected increased prescription and possibly the opening of fever wards. Wolverhampton guardians discussed the cost of alcohol consumption in 1867, as it had risen eightfold compared to a few years earlier. For the quarter year ending 1866, they had spent nearly £85 at a cost of 2s and 3d per inmate, while Birmingham spent above £134 at only 1s and 3d per head. The matter was raised by Mr Barker, who was denounced as a teetotaller by the other guardians, one of whom, Mr Willcock, was proud that the MO gave the 'sick poor' those stimulants he considered necessary, as he felt they did more good than all the medicines that were prescribed.[97]

[95] BPP, 1867-68 (4), p.16.
[96] WALS, WBG, PU/WOL/A/16, 20 November, 24 December 1874.
[97] WALS, *WC*, 3 July and 14 August 1867.

Table 5.1: Inmates, Patients and Alcohol Consumption in Wolverhampton Workhouse, 1842-46

	1842	1843	1844	1845	1846
Mean no. of inmates	442	478	419	374	-
Mean no. of patients	40	69	69	63	-
Ale (pints)	5,321	7,057	9,489	10,536	11,497
Wine (pints)	163	244	166	413	446
Brandy (pints)	1.5	10.5	5	8.5	9
Gin (pints)	173	307	457	685	823

Source: *Wolverhampton Chronicle*, 2 December 1846; WALS, Master's Journal, PU/WOL/U/2, 16 April 1842 to 16 August 1845.

The amount spent on wines and spirits to treat sick inmates in Birmingham workhouse increased from a weekly average of approximately £43 for the year 1832-33 to nearly £80 for 1842-43, but declined to annual costs of just under £57 in 1849 and nearly £39 in 1871. Over the same period, the number of patients rose from 122 to around 700.[98] The guardians did not raise the issue of cost at that time and the mostly likely reason for the reduction in the prescription of alcohol was a change in medical practice. Nevertheless, when the guardians were presented in 1876 with details of alcoholic 'liquors' prescribed over the previous five years, they instructed the MO to revise the list of inmates for whom it was allowed with a view to reducing consumption. This was despite considering the return as satisfactory.[99] At this time, Birmingham was already frugal in the amount of alcohol consumed in its institution, compared with Wolverhampton workhouse and the national average (Table 5.2). This is re-affirmed by the cost per patient, which is available for 1871 only. Birmingham spent 4s and 5d per patient, while Wolverhampton was more spendthrift at over £1,

[98] BCL, BBG, GP/B/2/1/3, 2 April 1833; GP/B/2/1/6, 24 April 1849; BPP 1872 (391), pp.24-25; BPP, 1870 (468-I), p.21; TNA, MH12/13286, MH12/13288.
[99] BCL, House Sub-committee (hereafter HSC), GP/B/2/3/3/5, 25 July 1876.

although this was two-thirds less than the national average, despite the WMO having to meet the cost of the drugs he prescribed.[100]

A national return on alcohol consumption in workhouses for 1881 was brought to the attention of Wolverhampton guardians. Birmingham had spent less, but could obtain ale and brandy at a lower cost and port wine at half the price per gallon.[101] When a

Table 5.2: Quantity and Cost of Alcohol Consumption in Wolverhampton, Birmingham and all English and Welsh Workhouses, 1871-1892

Place and Year	Quantity in Pints			Cost in £s			No. of Inmates	Cost per Inmate in £s
	Ale	Wine	Spirits	Ale	Wine	Spirits		
Birmingham								
1871	30,440	479	303	130	19	30	1,761	0.10
1881	7,656	302	1,264	36	11	131	2,119	0.08
1892	6,258	151	1,735	32	19	186	2,263	0.10
Wolverhampton								
1871	28,870	1,180	1,208	210	65	101	716	0.53
1881	28,584	447	1,037	183	29	104	972	0.33
1892	22,960	280	1,242	143	18	138	845	0.35
England & Wales								
1871	8,675,337	168,700	232,711	48,362	11,231	22,962	140,000	0.60
1881	6,541,128	114,497	183,233	33,839	7,148	19,316	170,566	0.35
1892	3,643,504	38,597	124,367	16,951	4,256	14,428	182,000	0.20

Sources: BPP, 1872 (391), pp.22-25, 36; 1883 (108), pp.4, 14-15; 1895 (44), pp.4, 25; Census data for 1871; Williams, *From Pauperism to Poverty*, p.159.

further return from the LGB was considered at the request of the chairman of the Workhouse Drink Reform League in 1888, the cost of consumption of wine and spirits had dropped to £8 and £42 respectively and the cost per inmate had fallen to 3s and 5d and to 8s and 7d per patient. Out of the 423 patients in the infirmary, only 14

[100] BPP, 1872 (391), pp.22-25, 36.
[101] WALS, *WC*, 11 July 1883.

had been prescribed alcohol, but it was also being given to inmates employed in disagreeable work, including those caring for epileptic patients. Without their help, eight extra nurses would have been required, costing an estimated £400 annually. The guardians were encouraged that the cost per inmate was lower than the average for urban unions and made no changes to existing arrangements.[102] Birmingham guardians were also concerned in the early 1880s that medical extras had become excessive and sought advice from the LGB. Their inspector, Dr Mouat, re-iterated one of the principles of the poor law in treating the sick, namely 'that they should be denied nothing that was essential to their health… but must not have luxuries or what they would not have in their own station in life'. He was, thus, applying the principle of less-eligibility to sick inmates, but, if alcohol was an essential treatment, those who were destitute would qualify for it whether at home or in the workhouse, and those who were poor could receive it in voluntary hospitals. It appears to have been used as a reason to limit consumption, as he went on to say that the effect of alcohol could be obtained by prescribed medicines, such as beef tea and Liebig's Extract. Despite this, medical extras increased the following year by 21 pints of brandy, as well as by 188 quarts of milk and 134 eggs, although the number of patients fell by 110.[103] Table 5.3 shows that ale and wine were ordered less over the twenty years, but that the amount of spirits rose. Overall, the cost per inmate stayed constant, although the proportion of sick inmates must have increased in that period. In the separate infirmary in 1892, the cost of alcohol per patient was 3s and 7d, only slightly less that in 1871 and about half the cost per patient of 7s and 5d fifty years earlier. [104] Thus, Birmingham's MOs were sparing in their use of alcoholic beverages, possibly because they did not pay for prescribed drugs, but another factor may have been that the temperance movement

[102] WALS, WBG, PU/WOL/A/22, 6 April 1888; BPP, 1886 (206), p.5.
[103] BCL, VGPC, GP/B/2/8/1/8, 23 June 1882.
[104] BPP, 1895 (44), p.25; BCL, BBG, GP/B/2/1/6, 9 and 24 April 1849.

was strong in Birmingham.[105] For example, Joseph Chamberlain introduced schemes for municipalising the drinks trade in the town in the second half of the nineteenth century.[106] At the end of the century, the amount of beef, eggs, milk, tapioca, poultry, port wine and brandy had increased in the infirmary despite the same average number of patients, but the volume of whisky consumed had deceased.[107]

In the last decade of the century, Wolverhampton guardians considered the latest parliamentary return on the consumption of alcoholic liquors in workhouses.[108] One guardian expressed the view that it was much greater in Wolverhampton than the majority of other workhouses and showed no sign of decreasing if the current MO remained in post. However, rather than calling for his resignation, the guardians decided to call the MO's attention to the desirability of reducing it, as the amount prescribed to the sick was in excess of other workhouses. They also prohibited the issue of alcohol to inmates not requiring it for medical reasons.[109] Table 5.2 suggests that Wolverhampton was above the national average for consumption per inmate, but that it had not changed from ten years before, whereas there had been a decline across the country. The following year, the auditor's report alleged misconduct on the MO's behalf in the prescription of 'intoxicating liquors' in the workhouse. Edward Watts denied the accuracy of the charges and gave an explanation of his practice of ordering stimulants in a written response, which the guardians accepted as a satisfactory answer.[110] Early in the twentieth century, the expenditure on spirits for the infirmary in the new workhouse was again under scrutiny. The additional bed capacity may

[105] J. Nicholls, *The Politics of Alcohol: A history of the drink question in England*, Manchester, 2009, p.138.
[106] Harrison, p.329.
[107] BCL, Infirmary House Sub-committee (hereafter IHSC), BP/B/2/4/5/2, 9 May 1901.
[108] The return in question was BPP, 1892 (292).
[109] WALS, WBG, PU/WOL/A/24, 25 November, 9 December 1892.
[110] Ibid., 17 March 1893.

have led to greater consumption, but, as Table 5.3 shows, the cost had increased before the move into the new institution in 1903, following which a greater range of spirits were provided.[111]

Table 5.3: Cost of Consumption of Wines and Spirits in Wolverhampton Workhouse, for the Years ending Lady Day 1900-1906

	1900	1901	1902	1906
Wine	£8	£12	£14	£16
Brandy	£56	£67	£66	£31
Whisky	-	-	-	£33
Gin	-	-	-	£1
Total for spirits	£56	£61	£66	£65

Source: WALS, WBG, PU/WOL/A/32, 6 April 1906.

Although Wolverhampton guardians were concerned over expenditure on alcohol, they also expressed a desire to obtain a good quality product. In 1899, they expressed a wish to pay 25s per gallon for port wine, but on being told by the clerk that this was not economic, they reduced the amount to 15s.[112] However, three years later, they raised this to 18s and decided that brandy should be three-star in quality.[113] The alcoholic strength of sherry was confirmed to be satisfactory for its use in making white wine whey, administered to patients suffering from diarrhoea. The other ingredients of this concoction were milk and boiling water and it was also used in the treatment of fevers.[114] Thus, there was conflict between the guardians' continual attempts to control the cost of alcohol consumption, and their desire to ensure that what was available was of sufficient quality to be an effective remedy.

[111] WALS, HC, PU/WOL/E/2, 27 March 1906.
[112] WALS, WBG, PU/WOL/A/28, 29 September, 18 and 27 October 1899.
[113] WALS, WBG, PU/WOL/A/29, 11 April 1902.
[114] WALS, WBG, PU/WOL/A/32, 18 October 1907; Williams, p.551.

The use of alcohol by WMOs for its perceived therapeutic benefits varied considerably between workhouses throughout the country. For example, Edward Davies, WMO in Wrexham, abandoned the use of alcoholic drinks in the treatment of disease in 1873. Cases of erysipelas, typhoid fever and pneumonia were managed with 'medicinal stimulants and nutritious diet', such as milk, eggs and beef tea. The mortality rate in the workhouse fell from 41 for the three years before his prohibition to 36 for the same period afterwards.[115] On the other hand, Alfred Sheen, MO to Cardiff workhouse and senior surgeon to Glamorgan and Monmouthshire Infirmary, cautioned against the liberal use of stimulants and advised that they should be ordered with the same care as was taken with the prescription of medicines. He applauded the reduction in their use and recommended the same approach as with patients in an 'ordinary hospital'. He was of the opinion that 'Cases of sickness occur where it would be a gross dereliction of professional duty, if not an act of culpable negligence, …to withhold stimulants'.[116] The expenditure at Cardiff workhouse on alcohol was modest at 10s and 7d per patient in 1871 and at similar levels per inmate in 1881 and 1892 (9d and 8d) as Birmingham.[117] This demonstrates that Sheen was moderate in his use of alcohol, while considering it essential for some patients. The medicinal use of alcohol remained a controversial topic among the medical profession throughout the nineteenth century.

[115] BPP, 1876 (202), pp.3-4.
[116] Sheen, pp.20-22.
[117] BPP, 1872 (391), pp.32-33; 1883 (108), p.19; 1895 (44), p.36.

Drug Therapy

Treatment in the nineteenth century was essentially symptomatic and most drugs were herbal products or mineral preparations. The choice of treatment regimen did not depend on the diagnosis or nature of the illness, as there were only two specific therapies, quinine for intermittent fever and mercury for syphilis.[118] The major component of the depletive regimen was cathartic drugs, which purged the patient, but were also thought to have a systemic stimulant effect. Although aloes, rhubarb and senna were used, the most popular purgative was calomel (mercurous chloride).[119] However, it produced severe side effects, with excessive salivation, inflammation and bleeding of the gums, loosening of the teeth, profuse sweating and, in more severe poisoning, loss of teeth and necrosis of the mandible.[120] Emetics, anodynes (analgesics), hypnotics and diaphoretics (drugs increasing perspiration) were included in the depletive regimen. Stimulant drugs consisted mainly of bitters and tonics to increase the general strength of the body and promote appetite and diuretics to promote the excretion of urine. The most popular was Peruvian bark containing quinine; but iron compounds were also used. Arsenicals, most commonly in the form of Fowler's solution, were thought to be useful for numerous conditions and regarded as a 'multi-potent drug'.[121]

Wolverhampton Board of Guardians became concerned in 1855 at the method employed in dispensing medicines in the workhouse. The nurse who was instructed by the MO to prepare pills of calomel passed the task onto one of the older female

[118] Warner, *Therapeutic Perspective*, pp.62-63.
[119] Risse, pp.192, 198.
[120] Ibid., pp.199-200; Warner, *Therapeutic Perspective*, p.141.
[121] J. C. Whorton, *The Arsenical Century*, Oxford, 2010, p.236.

inmates. As a result, it was given to patients without the required amount of mercury being weighed. Calomel was used to treat fevers and, for cholera, was given as 'blue pill with soap'.[122] Richard Nugent, MO, described the treatments in general use in the workhouse. The 'Universal Assafoetida Pill' was given to old women and 'asthmaticals'. It contained gum resin that was considered to be an antispasmodic and expectorant, useful for treating cough in older people. The other pills in general use were *Pil Hydrarg*, which contained only mercury dissolved in nitric acid, and *Pil Saponis cum Opio*, the soap considered to be beneficial for digestive disorders. However, the most frequently used medicine was 'Salts and Magnesia', which may have been a term used for *Magnesii Sulphas*, or magnesium sulphate, used as an antacid.[123] Because of the disquiet regarding the system of dispensing, the MO was requested to change the practice, but the guardians deferred discussion on the issue of whether all medicines should be purchased by them.[124] The MO was required to pay the cost of drugs he prescribed and he estimated this in 1866 as £50 *per annum* out of his salary of £130. He considered the guardians should have covered the cost of the castor oil and quinine required by patients.[125] The guardians decided against paying for medicines until ten years later, at which time they also appointed Samuel Richards as workhouse dispenser.[126] Eleven years later, they became concerned at the rising cost of the drugs bill and took steps to limit the amount of any drug dispensed to no more than that indicated on the prescription. They also requested the MOs to agree a common form of the main drugs used.[127]

[122] TNA, MH12/11682, 23 January 1856.
[123] Ibid.; T. J. Graham, *Modern Domestic Medicine*, London, 1848, pp.6, 56.
[124] WALS, *WC*, 14 February 1855; WBG, PU/WOL/A/9, 9 March 1855.
[125] WALS, *WC*, 3 October 1866.
[126] WALS, WBG, PU/WOL/A/16, 20 and 27 November, 11 December 1874.
[127] Ibid., PU/WOL/A/20, 5 June 1885.

Prior to the passing of the Poor Law Amendment Act (1834), Birmingham guardians employed two resident dispensing apothecaries in addition to the house surgeon.[128] Because of the increasing influence of the PLB, the guardians relieved the dispensers of their duties in 1850, in spite of the number of sick inmates increasing from an average of 135 in 1834 to 233 in October 1847.[129] The increased workload of the MO eight years later, with an average of 318 patients in the infirmary, made it necessary for the guardians to re-employ a non-resident dispenser.[130] The guardians became concerned that the expenditure on drugs had increased by over £217 in the six months from September 1886 to March 1887 compared to the equivalent period the previous year. The dispenser reported that prescriptions had increased by 120 daily between the two periods and a greater variety of drugs were used instead of 'stock' items. The purchase of iodoform, which was expensive, had cost around £40 and the use of another expensive drug, iodide of potassium, had increased threefold. The Infirmary Committee considered the additional outlay was justified as the number of sick inmates discharged from the infirmary to the workhouse or their homes had increased from 1,856 in the earlier period to 1,947 in the later one and deaths in the infirmary had decreased from 630 to 557. The Committee concluded that 'we can confidently assert that the Sick Inmates are made most comfortable, that their lives are prolonged, and that they are fully treated up to the scientific attainments of the present day'.[131]

When the infirmary moved to its new building in 1889, a temporary part-time dispenser was employed for the workhouse only, although the guardians considered

[128] BCL, BBG, GP/B/2/1/3, 16 November 1831.
[129] Ibid., GP/B/2/1/6, 11 December 1849 ;GP/B/2/1/3, 8 July 1834, 4 January 1835; GP/B/2/1/5 12, October 1847.
[130] Ibid., GP/B/2/1/15, 28 February 1855.
[131] BCL, ISC, GP/B/2/4/1/4, 25 November 1887; an abbreviated version of this quotation appears at the beginning of this chapter.

doing without one. Ebenezer Teichelmann, WMO, estimated that the 30 prescriptions he wrote daily for the treatment of workhouse inmates would take two hours to dispense and recommended the dispenser be continued for three hours each day. The large number of prescriptions was necessary as the majority of the 98 patients in the convalescent and new chronic wards were on medication.[132] In the new infirmary, it was decided to keep a stock of drugs in locked cupboards in the wards, but to have them sent to the dispensary for checking monthly (Appendix C).[133] They consisted mainly of purgatives, laxatives, expectorants, astringents, analgesics, tonics and stimulants, as well as ointments for local application. The following year, the ward list also contained morphine, cocaine and ether. Senior nurses were now allowed to give hypodermic injections in the presence of the MO.[134] To gain a better understanding of how drugs were employed in the workhouse, it is necessary to consider how specific disease states were treated.

'The Itch'

The itch was an ambiguous condition of the skin, which covered a variety of dermatological diseases. Despite its omnipresence in poor law institutions and its links to immorality and poverty, few historical studies have been undertaken since the first half of the twentieth century.[135] Although the itch was associated with venereal disease and leprosy, a common, but not universal cause was scabies caused by the mite, *Sarcoptes scabiei*, which burrows into the epidermis, where the female lays her

[132] BCL, WMC, GP/B/2/3/2/1, 11 April 1890.
[133] BCL, WIMC, GP/B/2/4/4/2, 15 May 1895.
[134] Ibid., 15 May 1896.
[135] K. Siena, 'The Moral Biology of "The Itch" in Eighteenth-Century Britain', in J. Reinarz and K. Siena (eds), *A Medical History of Skin: Scratching the Surface*, London, 2013, pp.71, 77, 234; this is the only contemporary text, but it does not extend beyond the eighteenth century.

eggs, usually in the hands of those infected. Intense itching follows, with a rash, which spreads up the arms. The disease is transmitted by direct skin contact and was accepted as contagious by the nineteenth century. The mite was identified in the mid-seventeenth century, but was not accepted as the cause of the disease until two hundred years later because doctors found it difficult to comprehend how a localised infestation could result in wide spread pathology and the mites were considered secondary to the infection.[136]

Many workhouses had dedicated wards for sufferers, for instance, in the mid-1860s, 52% of 48 provincial workhouses had itch wards or cutaneous wards.[137] However, they were often in detached buildings, such as an outhouse, and were dirty and repellent, partly due to 'a sense of disgust' at the nature of the condition.[138] For example, the two rooms used for the 'cure of the itch' in Birmingham workhouse in 1842 were described as in a filthy and disgusting state and alternative rooms were found.[139] Around the same time, patients with itch in Wolverhampton workhouse were being placed in the same ward as venereal patients.[140] The itch was very prevalent in workhouses, which led to it being perceived as a disease of the 'immoral' poor. There were more cases in Birmingham workhouse in the late 1870s (between 1% and 2% of inmates) than after 1894 (less than 1%), although the absolute numbers increased in the early twentieth century (Appendix B).[141] An outbreak of skin disease occurred among the children in Wolverhampton workhouse in the autumn of 1858, with 53 out of about 130 affected at its peak. The MO stated the cause as their

[136] L. C. Parish, 'History of Scabies', in M. Orkin and H. Maibach (eds), *Cutaneous infestations and insect bites*, New York, 1985, pp.4-8; Siena, ' Moral Biology', pp.72-73.
[137] BPP, 1867-68 (4), pp.26-157.
[138] Ibid., p.8.
[139] BCL, HC, GP/B/2/3/1/1, 2 August 1842.
[140] WALS, Master's Journal (hereafter MJ), PU/WOL/U/2, 5 November 1842.
[141] BCL, LGB Returns, GP/B/5/1/1-8, 1877-1911.

debilitated constitution and treated them with a full diet plus a small quantity of ale. By the following February, the number had reduced to 13.[142] However, a further outbreak took place 21 years later, affecting 22 children, caused by the admission of children with the disease.[143] Children appear to have been particularly susceptible. When Mary Kitson and her five children were transferred to Walsall workhouse from Wolverhampton in 1893, they were noted to be suffering from the itch and the heads of two of the children were in a 'filthy condition'.[144]

The traditional treatment was with sulphur, which was made into an ointment by mixing it with butter or hog's lard and had an offensive odour.[145] It was applied to the whole body, excepting for the face, and was re-applied over several days. It contaminated bedding and prevented patients from dressing. In 1857, John Wilmshurst, MO at Birmingham workhouse, requested permission to use a new method imported from Belgium, using a solution of sulphur and lime. This required only one application to achieve a cure and he pointed out it would allow more rapid discharge of patients and create more space in the infirmary for urgent cases. Wilmshurst introduced this treatment to Birmingham ten years before it became standard treatment in other workhouses and this is one example of the introduction of innovative treatment by a MO in a workhouse.[146]

[142] WALS, *WC*, 22 and 29 September, and 13 October 1858; 9 February 1859.
[143] Ibid., 1 September 1880.
[144] WALS, WBG, PU/WOL/A/24, 3 March 1893.
[145] Sulphur continues to be recommended as the treatment of choice for children and second line for adults.
[146] BCL, BBG, GP/B/2/1/19, 24 June 1857; BPP, 1867-68 (4), p.8.

Respiratory Disease

The invention of the stethoscope in the early 1800s by René Laennec, one of the greatest physicians of the French school, permitted him to identify normal from abnormal breath sounds and, as a result, to differentiate a variety of pulmonary diseases.[147] Respiratory disease was one of the commonest reasons for admission to hospital, accounting for 11% of admissions to the Royal Infirmary of Edinburgh in the late eighteenth century.[148] The mortality attributed to bronchitis, pneumonia and influenza increased in the second half of the nineteenth century, but declined sharply thereafter.[149] In December 1869, 8% of patients in workhouses in England and Wales were suffering from a non-tuberculous respiratory illness. However, in Birmingham they constituted 39% of patients and, in Wolverhampton, 27%, reflecting the industrial nature of those towns.[150] Respiratory diseases other than tuberculosis accounted for between 18% and 22% of deaths in Birmingham borough in the 1880s.[151]

Cornelius Suckling, Physician to the Queen's Hospital, Birmingham and Visiting Physician at Birmingham workhouse, published an account in September 1884 of his treatment of lobar pneumonia in 100 workhouse inmates over the previous 16 months. The disease is the commonest bacterial cause of community-acquired pneumonia, affects only one lobe of the lungs and is known now to be caused by *Streptococcus pneumoniae*. The overall mortality was 43%, rising with the increasing age of the

[147] Bynum, pp.37-38.
[148] Risse, *Hospital Life*, p.146.
[149] R. Woods, 'Mortality Patterns in the Nineteenth Century' in R. Woods and J. Woodward (eds), *Urban Disease and Mortality in Nineteenth Century England*, London, 1984, p.67.
[150] BPP, 1870 (468-I), pp.56, 57, 63, 327, 329.
[151] Woods, p.190.

patients. Patients he treated for pneumonia at the voluntary hospital were fitter pre-morbidity and had better outcomes than those at the workhouse. He pursued a stimulant plan of treatment in most of these cases, starting with cinchona and ammonia, and was convinced he had saved several lives by 'free stimulation' with alcohol. Quinine and occasionally a cold pack were used to treat a raised temperature. Pain was alleviated by 'morphia injections', hot poultices and a few leeches. He believed bloodletting to be dangerous in most cases of pneumonia and, on the only occasion he used it, the patient, who had marked cyanosis, had died. In four cases, he had seen early after the onset of the illness, he believed that he had aborted the disease by one dose of ten grains of quinine.[152] Early in the twentieth century, pneumonia was one of the commonest causes of death in Birmingham infirmary, declining from 14% (55 patients) in the first six months of 1905 to 6% (31) for the same period three years later. The guardians credited the decrease in morbidity to the change in the treatment of pneumonia that had taken place over those years, but, unfortunately, did not elucidate what that alteration had been.[153]

Dr Suckling's usual treatment for cough in patients with chronic bronchitis and emphysema, and chronic phthisis was a mixture of ammonia and senega.[154] He added a few grains of iodide of potassium if expectoration was difficult and a small quantity of lobelia if dyspnoea was marked. Most patients were also given cod-liver oil, as he considered it one of the most useful drugs in these conditions. Of 100 cases he treated in the winter of 1885, 28 were discharged well, with the chest examination being clear, and 68 discharged relieved. After reports of the benefit of pure terebene for

[152] C. W. Suckling, 'Lobar Pneumonia', *The Lancet*, ii (1884), p.407.
[153] BCL, Infirmary Management Committee (hereafter IMC), GP/B/2/4/4/5, 14 December 1908.
[154] Senega was the dried root of *Polygala senega*, a plant of the milkwort family. It was in common use as an infusion to treat pneumonia, probably for its perceived action as an expectorant.

winter-cough, he gave it a trial in a further 100 patients, giving five drops orally every four hours initially and increasing the dose to ten drops, whereas his previous mode of administration had been to let patients inhale it.[155] Oral administration resulted in 72% of patients with chronic bronchitis and 67% of the 6 cases of chronic phthisis being relieved, although the beneficial effect was mainly on their breathing as many requested an anti-tussive in addition. Suckling concluded that oral terebene was very effective in relieving the dyspnoea of chronic bronchitis.[156]

Venereal Disease

The poor law medical service was responsible, by default, for the management of the majority of patients with venereal disease. Those suspected of suffering this condition were frequently denied admission to voluntary hospitals, often on moral grounds, although the South Staffordshire General at Wolverhampton was an exception.[157] Specialist hospitals, often called 'Lock' or Skin Hospitals, were not established outside London until the later part of the century; for instance, the Skin Hospital in Birmingham (founded in 1881) first took inpatients in 1886 and then only twelve.[158] Kevin Siena found it difficult to estimate the general prevalence of sufferers of venereal disease in eighteenth-century workhouse infirmaries in London, as their proportion varied over time, for instance, from almost 4% in 1733 to 12% the

[155] Terebene is a mixture of dipentene and other hydrocarbons, distilled from oil of turpentine.
[156] C. W. Suckling, 'Pure Terebene in the Treatment of Winter-Cough', *British Medical Journal*, i (1886), p.541.
[157] Hodgkinson, pp.300-302; T. J. Wyke, 'Hospital facilities for and diagnosis and treatment of, venereal disease in England, 1800-1870', *British Journal of Venereal Diseases*, 49 (1973), pp.78-79.
[158] Reinarz, *Health Care in Birmingham*, p.110.

following year in St Margaret's parish.[159] Venereal disease was the term in common use in the nineteenth century to cover a host of sexually-transmitted diseases, the major ones being syphilis (or 'Great Pox') and gonorrhoea. However, Siena has cautioned against assuming that those diseases were exactly similar to the ones that are known by the same names at the present time.[160]

Syphilis first appeared in Europe in Italy at the close of the fifteenth century and rapidly spread as an epidemic, thereafter remaining endemic throughout the continent. The disease goes through three distinct phases after an incubation period varying from 10 days to 10 weeks. It first presents as a local infection, with a painless genital ulcer, or chancre, which heals. Secondary syphilis develops six to eight weeks later with fever, a rash of variable character, though usually maculopapular. Mouth ulcers may be present, as well as condylomata, which are warty lesions on the perineum. There follows a latent period of many years before late symptoms become manifest, with abscesses, destruction of the bones and face, as well as cardiovascular and neurological defects. The disease can be transmitted to the foetus from an infected mother, resulting in deformities in the child, such as the diagnostic 'peg-shaped' teeth, blindness and deafness.[161] Advances in aetiology and diagnosis did not take place until early in the twentieth century, with the isolation of the causative bacterium, called *Trepenonema pallidum* since 1906. The same year a diagnostic blood test, the Wassermann reaction, was developed, based on detecting antibodies to the bacterium. The test proves positive between five and eight weeks after infection has been

[159] K. Siena, *Venereal Disease, Hospitals and the Urban Poor: London's "Foul Wards", 1600-1800*, Rochester, 2004, p.150.
[160] Ibid., p.5l.
[161] M. Dobson, *Disease, the Extraordinary Stories Behind History's Deadliest Killers*, London, 2007, p.32.

contracted.[162] In 1914, Wolverhampton guardians agreed to make the test available at a cost of 15s *per* case, so that the MO could make an accurate return of the number in the workhouse for the Royal Commission on Venereal Diseases.[163]

The mainstay of treatment from the sixteenth century onwards was mercury, either ingested as a pill or applied locally as an ointment, although they were not curative. One of the most popular forms was the blue pill, which also contained confection of roses and powdered liquorice.[164] However, as the massive doses prescribed were not always effective and produced side effects, a non-mercurial plan of treatment, known as the 'simple plan' and based on the antiphlogistic regimen and local bloodletting, came into favour in the early nineteenth century.[165] Langston Parker, a surgeon at Queen's Hospital, Birmingham and an expert on venereal disease, recommended that treatment with mercury be withheld in primary syphilis until the patient had been prepared for it by means of the simple method.[166] However, he preferred to start it immediately for secondary manifestations.[167] The most important of the many alternative forms of treatment that were tried was iodide of potassium, introduced in 1836, but it became restricted to the treatment of tertiary disease. Powerful caustics such as nitric acid were used to treat sores and other local manifestations.[168] Although both mercury and iodine are treponemacidal, it is likely that they were only suppressive of clinical symptoms rather than curative.[169] In 1910, Paul Ehrlich, a German medical scientist, developed salvarsan, an arsenical compound as an effective

[162] BPP, 1913 [Cd. 7029], pp.11-12.
[163] WALS, HC, PU/WOL/E/4, 29 January 1914.
[164] Wyke, p.81.
[165] Ibid., p.81; L. Parker, *The Modern Treatment of Syphilitic Diseases,* Birmingham, 1840, paragraphs 1-15.
[166] Parker, paragraph 29.
[167] Ibid., paragraph 208.
[168] Wyke, pp.81-82.
[169] J. D. Oriel, *The Scars of Venus; A History of Venereology*, London, 1994, pp.88-89.

curative treatment, although it was subsequently amended to neo-salvarsan because of toxic side effects of the earlier preparation. It had to be administered with caution by intravenous injection and a number of injections were required until evidence of healing of lesions took place.[170]

Gonorrhoea is a bacterial infection that results in urethritis with a urethral discharge in the male and cervicitis, vaginal discharge and urethritis in the female. In both, a systemic reaction may occur with arthritis and a vasculitic rash. It was not clearly differentiated from syphilis until 1837 and the causative organism, *Neisseria gonorrhoea*, was identified in 1879. The major complications are urethral stricture in men and infertility in women due to infection ascending to the uterus and ovaries. The main form of local treatment was the instillation of antiseptic solutions of silver salts into the male urethra and the vagina in women, but oral therapy with copaiba was thought useful in men.[171]

The majority of workhouses had dedicated 'venereal' or 'lock' wards. In the mid-1860s, Birmingham workhouse provided one ward of ten beds for men and three wards with a total of 31 beds for women (Appendix H), while Wolverhampton had one ward of five beds for men and three wards, each with five beds, for women.[172] During the first week in January 1876, there were 55 patients with venereal disease in the Birmingham wards, constituting 6% of all sick patients, and eight (5%) in Wolverhampton, compared with an average of 2% in English workhouses.[173] However, Wolverhampton guardians accepted that there would be 'those who have

[170] BPP, 1913 [Cd. 7029], pp.16-18.
[171] Parker, paragraphs 100-1; copaiba was an oil-resin obtained by incising the trunks of several species of *Copaifera*.
[172] BPP, 1867-68 (4), pp.46, 153.
[173] BPP, 1877 (260), pp.10-11, 17.

come to be cured of venereal disease'.[174] At times, there were no venereal patients in Wolverhampton and only 26 beds were allocated for 'syphilitic and skin' patients in the infirmary in the new workhouse in 1903.[175] As a result, Wolverhampton's records contain few details regarding venereal patients and the treatment prescribed is not available from the minutes in either town. Nevertheless, in 1857, John Wilmshurst, WMO in Birmingham, claimed to provide superior treatment compared to that in other workhouses, where they were neglected by being 'dosed with salt and senna and discharged cured'.[176] Although he provided 'specific medical treatment', it is not clear whether he was using mercury, which had been in regular use in workhouses to treat venereal disease in the eighteenth century or perhaps the more recently introduced potassium iodide.[177] He attributed his treatment to attracting an increased number of venereal patients to the workhouse and his view was given some support by a statement from workhouse inmate Emma Rose, aged 23 years. Rose was a resident at Kidderminster, where she had been in the workhouse for three months. She claimed to have been confined to bed for that time, denied treatment and examination by the nurse revealed her condition had deteriorated. On the recommendation of a fellow venereal patient at Kidderminster, she had travelled to Birmingham with the express purpose of being admitted to the workhouse. The MO at Kidderminster workhouse supplied details of the treatment she had received when she was there. He believed she did not require 'internal remedies', but silver nitrate

[174] WALS, WBG, PU/WOL/A/13, 15 November 1867.
[175] WALS, WBG, PU/WOL/A/5, 23 August 1844; *Wolverhampton Journal Illustrated Vol. II*, LS/LO7/79, p.liv.
[176] BCL, VGPC, GP/B/2/8/1/2, 7 August 1857.
[177] Siena, *Venereal Disease*, pp.172-73.

had been applied daily for the removal of condylomata, as she had refused the quicker remedy of nitric acid.[178]

Toward the end of the century, the number of venereal patients in the workhouse in Birmingham diminished, totalling three males and seven females in September 1892. As a result, the guardians hoped to transfer them to the Lock Hospital on a payment per patient basis. However, this did not prove possible due to the pressure of work at the hospital and the limited number of twelve beds.[179] In 1912, the guardians arranged that venereal patients could be transferred temporarily to the 'Skin and Lock Hospital' for treatment with salvarsan for a course of therapy of up to ten days duration. They agreed a fee of 21s for one week or part of one week plus the cost of the drugs. In the following three months, Mary Whitehouse, Margaret Timmins, George Thomas and John Whitcombe all received salvarsan injections. Timmins returned to the workhouse much improved, but returned to the Lock Hospital for a second course of treatment, as did George Thomas.[180] It is of interest to note that the guardians preferred to refer these workhouse inmates to the specialist hospital for treatment, rather than arrange it at their own infirmary, which at that time was developing into a general hospital.

[178] BCL, BBG, GP/B/2/1/20, 18 November, 2 December 1857; condylomata are wart-like excrescences near the anus or vulva, which occur in the secondary stage of syphilis. Rose's statement is available in full in A. E. S. Ritch, '"Sick, Aged and Infirm'' Adults in the New Birmingham Workhouse, 1852–1912', (unpublished MPhil dissertation, University of Birmingham, 2010), pp.57-58.
[179] BCL, HSC, GP/B/2/3/3/14, 21 June, 11 October 1892; Anonymous, 'Weeding the Workhouse', *The Lancet*, ii (1892), p.638; Reinarz, *Health Care*, p.110.
[180] BCL, Western Road House Sub-committee, GP/B/2/3/15/1, 19 July, 20 September, 8 and 22 November, 6 December 1912.

Epilepsy

The Hippocratic Corpus included a treatise on the 'The Sacred Disease', as epilepsy was known as in the ancient world. However, it was not until the later part of the nineteenth century that the nature of the epileptic process was elucidated by Hughlings Jackson, a London neurologist who is regarded as 'the father of modern epileptology'.[181] His definition of the epileptic seizure, as a manifestation of a paroxysmal disturbance of brain function, remains the one in current use.[182] The most striking form of seizure is the *grand mal* fit, with sudden loss of consciousness, muscle spasm followed quickly by muscular jerking. Numerous therapies were employed, including antiphlogistic regimens, the most popular in the early nineteenth century being mistletoe, silver nitrate and zinc oxide.[183] However, none proved to be able to prevent fits or reduce their frequency. The first drug to achieve this effect was potassium bromide, first reported in 1857 to have been tried as a result of a chance association. Subsequent reports over the next three decades confirmed that it had virtually superseded all other drugs in the treatment of epilepsy, though it did have the side effects of physical weakness, mental dullness and skin rashes, known as bromism.[184] The next development in drug therapy, the introduction of phenobarbitone, did not take place until 1912.

[181] W. J. Friedlander, *The History of Modern Epilepsy: The Beginning, 1865-1914*, London, 2001, p.2.
[182] M. J. Eadie and P. F. Bladin, *A Disease Once Sacred*: *A History of the Medical Understanding of Epilepsy*, Eastleigh, 2001, pp.4, 147.
[183] D. F. Scott, *The History of Epileptic Therapy*, Carnforth, Lancs, 1993, pp.37-38.
[184] Ibid., pp.49-50; Friedlander, p.277.

From the beginning of the nineteenth century, epileptics were confined with the insane in asylums and workhouses.[185] In the latter, they were usually accommodated in what were called the 'lunatic' or 'insane wards', although in Birmingham the name was altered in the second workhouse in 1852 to 'epileptic wards'. Any inmate with any type of fit would be classed as epileptic and many of the children with fits would also suffer from mental disability. In the mid-1860s, there were 30 epileptic patients in Wolverhampton workhouse, constituting 4% of total inmates and 13% of those designated as sick; for Birmingham, the equivalent figures were 133 patients, 7% of inmates and 20% of the sick.[186] Nationally, 4% of patients in workhouses suffered epileptic seizures in 1870.[187] The number of epileptic patients increased over the next twenty years to 57 (6% of all inmates) in Wolverhampton and to 323 (145 of inmates) in Birmingham.[188] It is surprising that, as they were a significant proportion of sick inmates, so little information about them has been recorded in the guardians' minutes, but epileptics were usually included in the reports of the Commissioners in Lunacy (hereafter CsL). Birmingham's WMO in 1882 was of the opinion that many inmates were classified as imbeciles, who were epileptic but had no mental disorder.[189] At the end of the century, there were 12 sane epileptic patients admitted to a workhouse from Wolverhampton County Borough and 118 from Birmingham County Borough. In Wolverhampton at that time, 13% of patients in the insane wards were sane epileptics.[190]

[185] O. Temkin, *The Falling Sickness*: *a history of epilepsy from the Greeks to the beginnings of modern neurology,* Baltimore, 1971, pp.255-56.
[186] WALS, *WC*, 11 and 25 December 1867; BPP, 1867-68 (4), p.153; BCL, VGPC, GP/B/2/8/1/4, 22 May 1865.
[187] BPP, 1870 (468-I), pp.24-25, 54.
[188] WALS, *WC*, 28 June 1882, 14 March 1883; BCL, VGPC, GP/B/2/8/1/9, 14 August 1885.
[189] BCL, VGPC, GP/B/2/8/1/8, 27 October 1882.
[190] BPP, 1900 (362), pp.2-3; WALS, WBG, PU/WOL/A/28, 2 February, 8 June 1900.

In July 1845, Thomas Green, one of the visiting surgeons to Birmingham infirmary, took on the responsibility for the 'lunatic department'. His detailed case notes are available for the 824 patients admitted over the next five years, until he resigned to take up the post of medical superintendent at the newly opened Borough Lunatic Asylum (Table 5.4).[191] Of the 42 admissions in the first year, 9 required some form of restraint. George Proctor, aged 17 years, was prone to violent fits, which he had had from childhood, and wore a pair of boots at night, which were secured to the bedstead. William Roper, aged 20, was one of six patients who were secured at night with a strap, which went over the top of the bedclothes and was fastened to the sides of the bed. He and Frederick Wade, aged 25, also wore boots at times as well as the strap. In the case of Fanny Docker, aged 17, the strap was used to prevent her falling out of bed. It was tied to one side of the bed only when used for Emma Oxford, who had been having continual episodes of fitting for one week with seizures that were always 'very violent'. However, Hannah Hoskins, whose fits occurred at intervals of one to two weeks, only required 'slight restraint' after some attacks. Venesection was used to good effect initially on 42-year-old James Benham, who had been epileptic for 25 years. When his fits returned after two months with greater violence, a further 16 ounces of blood was taken from his arm, but the result is not recorded. Frederick Wade's fits had become less violent than at the time of admission in 1843. However, in April 1846, he became more violent again after fitting. He was noted to be deaf, have increasing enlargement of the 'glands of the neck', and was treated with one milligram of iodine, presumably as the swelling was thought to be a goitre.[192] The clinical picture would be in keeping with a diagnosis of hypothyroidism.

[191] BCL, BBG, GP/B/2/1/5, 22 July 1845; GP/B/2/1/6, 30 October 1849; Register of Insane (hereafter RI), MH/344/12/1, 1845.
[192] BCL, RI, MH/344/12/1, 1845-50.

Although the CsL forbade the use of mechanical restraint, workhouse staff found it difficult to manage epileptics and lunatics without it.[193] They were commonly used in asylums in the first half of the nineteenth century, especially confining patients to their bedsteads by means of straps. [194] When, in 1852, the CsL recommended to Wolverhampton guardians that straps and 'all other means of coercion' should be removed for use by the attendants and kept locked up, the guardians complied.[195] However, when they criticised the use of restraint in Birmingham a few years later, the workhouse master defended the practice as it was being used to prevent the women concerned from falling out of bed.[196] In Wolverhampton in the mid-1870s, the danger of a fall from bed was minimised by allowing all the 18 epileptic women and 25 men to sleep in low bedsteads with padded headboards and sides.[197] However, these beds were not in use in Birmingham infirmary 15 years later, although an attendant was present throughout the night to provide surveillance.[198] At the end of the century, a restraint jacket was still available on the wards in Wolverhampton, although it was only used occasionally during the transfer of inmates to the asylum.[199]

There is no evidence to determine whether bromides were used in either workhouse, but potassium bromide solution is listed in the pharmacopeia of Cardiff workhouse in 1890.[200] Nevertheless, frequent accounts of numerous fits taking place on the wards continue after the introduction of this remedy. During a visit by a Commissioner in Lunacy (hereafter CL) to Wolverhampton workhouse in the late 1860, several of the

[193] G. M. Ayers, *England's First State Hospitals and the Metropolitan Asylums Board 1867-1930*, London, 1971, p.40.
[194] L. D. Smith, 'Behind Closed Doors; Lunatic Asylum Keepers, 1800-60', *Social History of Medicine*, 1 (1988), pp.320-21.
[195] WALS, WBG, PU/WOL/A/8, 7 May 1852; *WC*, 12 May 1852.
[196] BCL, VGPC, GP/B/2/8/1/2, 9 November 1855.
[197] WALS, *WC*, 3 January 1877.
[198] TNA, MH12/13365, 26 February 1892.
[199] WALS, Workhouse Visiting Committee (hereafter WVC), PU/WOL/A/2, 1 February 1900.
[200] Sheen, p.79.

30 epileptic patients were lying on the floor fitting. The previous year, Edmund Howell sustained a severe injury to his nose when he fell at the onset of a seizure and, fifteen years later, one epileptic patient fractured his ankle as a result of banging his leg on the bathroom floor during a fit.[201] In Birmingham workhouse in the early 1870s, Eli Ensor, aged 28 years, had a seizure around every seven days, Downes Ireland, 32 years, once per month and Elizabeth McGuire, 32 years, every seven to ten days.[202] Dr Cornelius Suckling, Visiting Physician to Birmingham workhouse, provided details of the number of fits occurring per week among the 33 to 39 men in the epileptic wards over nine weeks in 1889. They ranged between 89 and 168, with a mean value of 138 and a median of 149. In addition, one man suffered 150 fits in one week.[203] A few years before, the guardians received a letter of thanks from the Vice-Consul of Sweden and Norway on behalf of one of his countrymen, F. Broderson, who had been a patient in the epileptic ward, where he was surprised when he saw

Table 5.4: Epileptic and Insane Patients in Birmingham Workhouse, by Gender, 1845-50

	Patients with Epilepsy only		Patients with Epilepsy and Mental Disorder		Total of Patients in Lunatic Wards	
	Male	Female	Male	Female	Male	Female
1845	19 23%	14 19%	4 5%	5 12%	82	42
1846	12 16%	8 11%	7 11%	4 6%	75	63
1847-50	29 13%	33 15%	32 15%	17 8%	223	212

Source: BCL, Register of Insane, MH/344/12/1.

[201] WALS, *WC*, 25 December 1867, 11 July 1866, 22 June 1881.
[202] BCL, HSC, GP/B/2/3/3/2, 16 May 1871.
[203] BCL, IMC, GP/B/2/4/4/1, 11 February 1889; full details of the number of fits is contained in Ritch, '"Sick, Aged and Infirm'' Adults', p.35.

what could be done for the patients.[204] However, it is not clear if he was epileptic or suffering from mental illness.

Patient Management and Mismanagement

A greater understanding of how treatments were utilised can be gleaned from consideration of the management of individual patients. Workhouse inmates had high expectations of treatment from MOs and would complain to the guardians if it was not to their satisfaction. Benjamin Lane, an inmate of Wolverhampton workhouse in April 1855, had initially been suffering from 'white swelling' of the knee, for which he was prescribed a flannel to wrap round the joint.[205] Later, he developed a pain in his side and diarrhoea, for which he was given a mustard plaster and he subsequently recovered. However, he complained that it took three requests to the MO, Richard Nugent, before he received treatment for his bowel complaint.[206] Joseph Freeman also complained of abdominal pain on admission in June 1894 and explained that it was four days since he had had a bowel movement. The MO gave him a 'draught to relieve pain'. He was transferred from the old men's ward to the infirmary as the doses of laxatives and castor oil were unsuccessful and his condition had deteriorated. An injection of an analgesic and oral lime water and brandy produced a little improvement, but he died the next day.[207]

Patients were also critical of the type of treatment prescribed by MOs. William Stanley and John Dyer criticised Nugent's practice of using the same medicine for

[204] BCL, VGPC, GP/B/2/8/1/9, 26 September 1884.
[205] 'White swelling' was the term used to denote tubercular infection of the joint.
[206] WALS, *WC*, 4 April 1855; TNA, MH12/11682, 5 April, 27 October 1855.
[207] WALS, WVC, PU/WOL/H/1, 15 June 1894.

between 20 and 30 different cases in Wolverhampton infirmary. They considered that not everyone's sickness was alike and that therapy should have been prescribed according to individual complaints and constitution. Nugent dismissed their criticism by claiming that 'this class of case' would never be satisfied whatever treatment was used.[208] An anonymous letter to the *Birmingham Journal* in 1857 complained that Birmingham guardians did not believe in any medicines more expensive than 'epsom salts', and restricted the MO's use of drugs. The accusations, which had been made by Daniel Smith, who had been an able-bodied inmate, were denied by the MO, who stated that he treated inmates with the same drugs and stimulants as he would use for private patients.[209] However, there were few complaints over eighty years and the most likely explanation is that patients usually received the attention they expected.

Inmates were also at risk of inadvertently being given the wrong medication, although only one incident has been recorded in the minutes of both boards of guardians. In 1898, probationer Nurse Stockwin in Birmingham workhouse infirmary admitted that she gave two patients a dose of lead lotion instead of ward mixture. She called promptly for medical attention and both patients recovered without incident. Both medicines were contained in identical bottles, although that containing lead lotion had the word 'poison' attached to it. It was usually kept in the poison cupboard, but had been lying out on the ward as it had been in use. The nurse was reprimanded for carelessness and the guardians took steps to provide distinctive bottles in future for poisons.[210] The lotion in question was likely to have been lead acetate, also known as sugar of lead, which was used as an astringent. More hazardous than the incorrect drug administration was the need for surgical operation.

[208] TNA, MH12/11682, 2 February 1855, 23 January 1856.
[209] BCL, VGPC, GP/B/2/8/1/2, 4 September 1857.
[210] BCL, IHSC, GP/B/2/4/5/1, 19 December 1898.

Surgery

The practice of surgery was revolutionised in the middle of the nineteenth century with the development of inhalation anaesthesia and antiseptic techniques, which have been hailed by some as the greatest innovations ever made in medical theory or practice.[211] Although they made more complex surgery possible, the most commonly performed surgical procedures were amputation, setting fractures and treating wounds. The period up to the First World War has been designated localistic, with the emphasis on resection of tumours, inflammations and injuries.[212] The operations carried out in Birmingham workhouse are an accurate reflection of this period, although more complex surgery took place from the 1880s (Table 5.5). A few instances of minor surgery in Wolverhampton workhouse have been recorded. In 1855, Richard Nugent lanced Arthur Belcher's lumbar abscess and applied poultices. When George Roberts was admitted having cut his throat, Nugent sutured and bandaged it, later applying poultices with astringent lotions.[213] Later surgery involved the removal of 'gravel' in the bladder of four-year-old Henry Weckman in 1861 and 'shot' from the abdomen of Samuel Perks in 1900.[214] There were few surgical patients in Wolverhampton in the decades after the NPL, with only one out of a total of 285 sick inmates on one day in mid-December 1869. This contrasts with Birmingham where there were 55 acute and 56 chronic surgical patients, each type corresponding to 8% of total patients, compared with the national figures of 6% and 10%.[215] A similar position occurred in Reading union workhouse, with four acute

[211] A. T. Youngson, *The Scientific Revolution in Victorian Medicine*, London, 1979, p.212.
[212] U. Tröhler, 'Surgery (modern)', in W. F. Bynum and R. Porter (eds), *Companion Encyclopaedia of the History of* Medicine, London, 1993, p.980.
[213] TNA, MH12/11682, 2 February 1855.
[214] WALS, WBG, PU/WOL/A/11, 3 May 1861; HC, PU/WOL/E/1, 30 October 1900.
[215] BPP, 1870 (468-I), pp.3, 19, 21.

(5%) and eight chronic (10%) surgical patients out of a total of 79. This was despite a ruling by the guardians the year previously that all paupers with fractures and all emergency cases should be directed straight to Royal Berkshire Hospital, for which purpose they increased their annual subscription from six to ten guineas.[216]

Birmingham guardians required the MO to seek their consent for inmates to have surgery and preferred them to be transferred to the General Hospital for the operation. This ensured that the decision to carry out surgery was approved by more than one surgeon.[217] When amputation of Mary Norton's leg because of 'disease of the knee' was recommended to the guardians in 1851 and of the arm of the 'man, Trafford' for a diseased elbow in 1854, they suggested further surgical opinions.[218] The guardians' position was challenged by one WMO, Redfern Davies, when he amputated Edward Waite's leg in the workhouse without permission, although he eventually had to concede he would only do so again in an emergency (Table 5.5).[219] However, Davies had performed other surgical procedures in the workhouse prior to that time and published details in medical journals. The following decade, Davies' successor, Edmund Robinson, declared that there were hardly any surgical cases in the workhouse and 'capital operations' did not take place there.[220] However, he found it necessary to amputate John Walsh's leg for malignant disease in the workhouse in 1867, as he was too ill to be transferred to hospital (Table 5.5). By the mid-1880s, the number of operations in the workhouse had increased, but after the opening of the new infirmary at the end of the decade, details of the surgery performed there are mostly available from published case reports, which contain the more difficult and

[216] Ibid., p.4; M. Railton and M. Barr, *Battle Workhouse and Hospital 1867-2005*, Reading, 2005, p.44.
[217] BCL, VGPC, GP/B/2/8/1/2, 8 January 1858; BBG, GP/B/2/1/22, 9 February 1859.
[218] BCL, BBG, GP/B/2/1/9, 23 July 1851; GP/B/2/1/14, 24 February 1854.
[219] BCL, BBG, GP/B/2/1/23, 22 June 1859.
[220] BPP, 1867-68 (40), p.45.

Table 5.5: Operations Performed in Birmingham Infirmary, 1859-1892

Date	Surgeon	Patient	Operation	Outcome[221]
June 1858	Redfern Davies	Henry Bagotts 8 years	Removal of glandular enlargement in neck	Breathing improved
December 1858	Redfern Davies	Male 17 years	Compression of varicocele	Radical cure
February 1859	Redfern Davies	Patrick Coyne 32 years	Drainage and repair of hydrocele	Radical cure
June 1859	Redfern Davies	Edward Waite	Amputation of leg	Patient died
December 1860	Redfern Davies	E.S. (female)	Repair of prolapse of uterus	Successful
January 1867	Edmund Robinson	John Walsh	Amputation of leg for disease of knee	Successful
May 1872	Adam Simpson	Richard Windsor 57 years	Repair of strangulated hernia	Patient died
June 1887	Jordan Lloyd	B. (female) 47 years	For acute intestinal obstruction due to incarcerated loop of bowel	Complete recovery
May 1889	Jordan Lloyd	Catherine B 38 years	For sub-acute intestinal obstruction due to cancer of colon	Colostomy; tumour inoperable
January 1891	Ebenezer Teichelmann	A.R. (female) 22 years	Removal of ruptured pyo-salpynx and ovary	Complete recovery
May 1892	Jordan Lloyd	M.A.H. (female) 40 years	Colpo-hysterectomy for cancer of cervix of uterus	Successful

Sources: BCL, BBG, GP/2/1/23, 8 June 1859, VGPC, GP/B/2/8/1/6, 10 May 1872; R. Davies , 'Birmingham Workhouse Infirmary', *British Medical Journal*, i (1858), p.284; R. Davies, 'Birmingham Workhouse Infirmary', *British Medical Journal*, i (1859), p.677; J. R. Davies, 'On the radical cure of Varicocele', *The Lancet*, ii, (1861), p.60; R. Davies, 'Remarks on the Operative and Mechanical Treatment of Prolapsus Uteri', *The Lancet*, i (1864), p.407; J. Lloyd, 'On Acute Intestinal Obstruction and its Treatment by Abdominal Section, with Illustrative Cases', *The Lancet*, i (1890), pp.996, 844, 1891; Anonymous, 'Birmingham Workhouse Infirmary. A Case of Peritonitis Following Parturition' *The Lancet*, ii (1891), pp.1276-77; J. Lloyd, 'Reports on Medical and Surgical Practice in the Hospitals and Asylums of Great Britain, Ireland, and the Colonies. Birmingham Workhouse Infirmary', *British Medical Journal*, i (1892), p.16.

[221] The outcome is as defined by the surgeon.

rarer cases, rather than routine surgical procedures.[222] Nevertheless, Dr Stuart, assistant surgeon, performed 45 major and 10 minor operations over a three-month period in 1913.[223] At that time, the surgeons had the benefit of X-ray apparatus, which proved invaluable in confirming a suspected kidney stone in a man admitted with vague abdominal symptoms. Jordan Lloyd successfully removed the stone and the patient was discharged cured. Another successful removal was possible after X-ray confirmed the exact site and extent of tuberculous disease in the bone of a patient's foot. The machine was also useful in the diagnosis of the large number of cases being admitted with suspected fractures.[224] Wolverhampton WMOs did not publish case reports, but Woodward Riley, while acting as deputy to Henry Gibbons, did so in 1870. He repaired successfully a small femoral hernia in David B., a 90-year-old inmate, after attempts at reduction had failed. He administered chloroform himself as he was 'rather pressed for time'.[225] In all the operations listed in Table 5.5, anaesthesia was used in the form of chloroform or ether and was administered by an assisting surgeon.

At the beginning of the twentieth century, the infirmary in Birmingham took on more acute medical work and became more akin to a general hospital. For the twelve months to May that same year, 1,137 surgical cases had been admitted, representing 34% of all admissions.[226] The number of operations carried out in Wolverhampton workhouse at the beginning of the twentieth century can be estimated from the record of payment to a second surgeon for administering anaesthetics. It increased from 4 in

[222] BCL, Infirmary Sub-committee, GP/B/2/4/1/4, 25 November 1887.
[223] BCL, Infirmaries Committee (Hospitals), GP/B/2/4/8/1, 9 July 1913.
[224] BCL, IMC, GP/B/2/4/4/6, 23 October 1911.
[225] J. W. Riley, 'Operation for strangulated femoral hernia in a man ninety years of age; recovery', *The Lancet*, ii (1879), p.110.
[226] BCL, IMC, GP/B/2/4/4/5, 11 July 1910.

1901 to 42 in 1902, but decreased to 14 in 1903 as the appointment of an assistant MO for the workhouse in that year allowed the anaesthetic to be given by him without additional payment.[227] Although surgical operations were uncommon in both workhouses in the mid-1880s, this form of medical care gradually increased in frequency and importance into the twentieth century.

Summary

In 1887, Birmingham guardians considered that the medical care in the workhouse was of such a high standard that patients were treated according to current scientific knowledge.[228] This chapter has provided some evidence to support this claim. The extent of medical prescriptions ordered by the MOs required the services of a dispenser at both workhouses, over most of the study period. Some of the MOs introduced therapies that were innovative, for instance, John Wilmhurst's treatment for scabies and Suckling's use of oral terebene for chronic bronchitis; or treated workhouse inmates more rigorously than patients in the voluntary hospital, as in the management of pneumonia. Redfern Davies attempted to introduce new surgical techniques and groundbreaking surgery, with some success in spite of the guardians' objections. However, much of this innovative medical practice in Birmingham only comes to light because the medical practitioners were motivated to publish their practice to improve their standing in a competitive medical market. Birmingham workhouse is conspicuous because of the extent to which its MOs practised a high standard of medical care. Although there is no evidence of innovation in

[227] WALS, WBG, PU/WOL/A/29, 22 November 1901; 3 January, 6 June, 14 November, 5 December 1902; 17 July 1903.
[228] BCL, ISC, GP/B/2/4/1/4, 25 November 1887.

Wolverhampton, it does not mean that the care provided was of an inferior quality. New methods of treatment did occur in other workhouses, for instance, the WMO in Leicester treated leg ulceration by skin grafting in the early 1870s, only a few years after the method was published in *The Lancet*.[229] Drugs in general use at the time, such as mercurials, made up the therapeutic armamentarium in workhouse infirmaries, in addition to a range of physical therapies. The workhouse provided care for the majority of sufferers from venereal disease, who were allowed access to newly introduced drug therapy in the early twentieth century.

WMOs provided a range of sick diets, tailored to specific conditions and the severity of the illness, as was the case in voluntary hospitals. With medical extras, additional nutrition, usually a form of meat, could be provided to suit individual patients. Alcohol was regarded as one of the most potent forms of drug therapy in the nineteenth century. Despite becoming less popular towards the century's end, few leading practitioners of the day advocated dispensing with it completely, since they believed it to be effective even if they were in dispute over its mode of action. It was used therapeutically in workhouse infirmaries, liberally in some, but more frugally in others, depending on where the MO stood in the alcohol debate. Whether guardians or the MO paid for drugs and whatever the degree of local influence of the temperance movement, these factors had only a limited effect. Historians' allegation that the main reason for the prescription of alcohol was evasion by the MO of the cost of drug therapy does not appear justified. Rather, the evidence in this chapter suggests it was the strongly held belief in its power to affect a cure. There is some evidence from Wolverhampton that guardians also believed in the therapeutic benefits

[229] A. Negrine, 'Medicine and Poverty: A Study of the Poor Law Medical Services of the Leicester Union 1876-1914', (unpublished PhD thesis, University of Leicester, 2008), pp.80-81.

of alcohol, although they continually strove to restrict consumption, as they did with most other forms of expenditure. In this respect, they were no different to managers at voluntary hospitals, where restrictions on the medical use of alcohol were put in place. However, they do not appear to have had much success in Wolverhampton and Birmingham in curtailing its use. The evidence from these workhouses suggests that MOs continued to prescribe food, alcohol, drugs and other treatments despite pressure for restriction by guardians or outside agencies. Furthermore, the standard of care they provided was at times exemplary. The main factor limiting the treatment of patients was the capability of the nursing staff at administering the MOs' orders and this aspect will be addressed in the next chapter.

CHAPTER 6

STANDARDS OF NURSING PRACTICE

'[I have] never observed sympathy between nurses and patients in public institutions.'[1]

During the nineteenth century nursing practice underwent major reform. At the time the New Poor Law (hereafter NPL) was enacted in 1834, the majority of nursing care in workhouses and workhouse infirmaries was carried out by inmates, who were predominantly older women. They were rewarded for their work with extra rations, which often included beer and gin, gaining them the reputation of working frequently in a state of intoxication. Pauper nurses were prone to be unreliable, incompetent, at times cruel, and liable to steal food and medication meant for patients.[2] It was acceptable in the nineteenth century to imbibe alcohol while at work, though nurses in voluntary hospitals were also supplied with alcohol, often as part of their remuneration, and drunkenness among these nurses was therefore also not

[1] Wolverhampton Archives and Local Studies (hereafter WALS), *Wolverhampton Chronicle* (hereafter *WC*), 23 May 1860.

[2] The majority of accounts of the poor law medical service make only brief mention of nursing care, possibly because it is the least well-documented part of the service within the archival records. The only dedicated accounts are R. White, *Social Change and the Development of the Nursing Profession: A Study of the Poor Law Nursing Service, 1848-1948*, London, 1978; M. Lorentzen, "'Lower than a scullery maid'", *Nursing History*, 3 (2003), pp.4-15. Sections on poor law nursing care appear in R. Hodgkinson, *The Origins of the National Health Service*, London, 1967, pp.556-72; M. Higgs, *Life in the Victorian and Edwardian Workhouse*, Stroud, 2007, pp.127-36; B. Abel-Smith, *A History of the Nursing Profession*, London, 1960, pp.36-49; C. Maggs, 'Nurse Recruitment to Four Provincial Hospitals 1881-1921', in C. Davies (ed.), *Rewriting Nursing* History, London, 1980; A. Negrine, 'Medicine and Poverty: A Study of the Poor Law Medical Services of the Leicester Union, 1867-1914', (Unpublished PhD thesis, University of Leicester, 2008), pp.98-122; M. E Baly, *Florence Nightingale and the Nursing Legacy*, London, 1986, pp.20-40; R. Dingwall, A. M. Rafferty and C. Webster (eds), *An Introduction to the Social History of Nursing*, London, 1988, pp.66-76; S. Williams, 'Caring for the sick poor: poor law nurses in Bedfordshire, c.1770-1834', in P. Lane, N. Raven and K. D. M. Snell (eds), in *Women, Work and Wages in England, 1600*-1850, Woodbridge, 2004, pp.141-69. Comments on the standard of workhouse nurses are contained in T. Rogers (ed.), *Joseph Rogers, MD. Reminiscences of the Workhouse Medical Officer*, London, 1889, pp.4-13, 246.

uncommon.[3] It was unusual for non-pauper personnel to be paid to carry out nursing duties in workhouses prior to the NPL and for several decades afterwards, although paid nurses did become more common after the act. Nevertheless, most London workhouses still did not employ any paid nurses in the 1850s.[4] This is not entirely surprising since the central authority never made it obligatory to employ nursing staff. The 14th Annual Report of the Poor Law Commissioners (hereafter PLCs) in 1847 listed the nurse as one of the officers of workhouses, giving guardians the right to appoint remunerated nurses. Eighteen years later, the Poor Law Board (hereafter PLB) issued a circular to metropolitan guardians advising the employment of paid nurses to promote better nursing in workhouses and stressing they be adequately remunerated.[5] In the same year, *The Lancet* set up an investigation into the state of workhouse infirmaries and subsequently campaigned for the employment of paid nurses to ensure 'a thorough and genuine performance of [nursing] duties'.[6] In 1892, Dr Downes, Medical Inspector for the Local Government Board (hereafter LGB) issued a letter stating that paupers were not suitable for employment on nursing duties and suggested a paid nurse to patient ratio between 1:15 and 1:10, but the LGB only advised guardians that they should feel satisfied that the number of nursing staff was adequate for the care of those inmates who were sick. Three years later, the board issued a circular letter stressing that a nurse was required to have experience in the treatment of the sick, was to be competent, and requesting guardians to discontinue the use of inmates as assistant nurses 'as far as possible'.[7] Finally, in 1897, the LGB issued an order banning inmates carrying out nursing duties, but continued to sanction

[3] Abel-Smith, p.9. Further discussion on the supply of alcohol to nurses can be found in chapter 5.
[4] Ibid., p.10.
[5] British Parliamentary Papers (hereafter BPP), 1866 (469), pp.1-2.
[6] Anonymous, 'The Lancet Sanitary Commission for investigating the State of the Infirmaries of Workhouses', *The Lancet*, ii (1865), p.19.
[7] White, pp.78-81.

their employment as attendants, working under the supervision of a paid nurse, who required only practical experience in nursing, and with the approval of the medical officer. After the NPL, guardians were slow to appoint paid nurses, so that by 1849 there were only 171 employed in England and Wales.[8] As a result of the 1866 circular, there was a considerable expansion in their numbers in metropolitan workhouses, from 111 in that year to 748 in 1883-84, while, in the country as a whole, the 884 paid nurses employed in 1870 represented a large increase in their number five years previously.[9] By 1896, their number had risen to 3,715 nationwide, with around 40% in London.[10] In the 40 years from 1869, sick inmates had more than doubled to over 100,000.[11] However in the 1890s, inmates were still being employed as paid attendants to supplement the non-pauper nursing staff. Patient to nurse ratios were higher in poor law infirmaries than in voluntary hospitals; for instance, in 1909, the number of beds per nurse in infirmaries ranged between 7.2 and 22.2, while in voluntary hospitals it was between 2.1 and 4.7, depending on how much surgery was carried out in an institution.[12]

The next development to influence the standard of nursing care in workhouse infirmaries was the introduction of trained nurses. Five years after the Nightingale School of Nursing opened at St Thomas' Hospital, London in 1860, 12 nurses from the school were sent to Brownlow Hill infirmary in Liverpool on a trial basis.[13] The scheme was regarded as successful in improving the nursing standards and trained nurses were gradually introduced throughout the country. A training school was set up

[8] BPP, 1849 (306), p.1.
[9] Ibid., p.51; Hodgkinson, p.570.
[10] BPP, 1896 (371), pp.4-5; Abel-Smith, p.51.
[11] Abel-Smith, p.51.
[12] BPP, 1909 [Cd. 4573], pp.48-49.
[13] The development of the Nightingale school of nursing is described in Baly, *Florence Nightingale and the Nursing Legacy*.

at the infirmary and other workhouse infirmaries followed suit, particularly in London and the other large cities. However, the introduction of training was slower and more difficult in workhouses than voluntary hospitals because of the LGB's stance that all staff must be accountable to the guardians.[14] One result was a severe shortage of trained nurses to satisfy the requirements of the infirmaries. To ease the problem of nurse recruitment, the Association for Promoting Trained Nursing in Workhouse Infirmaries and Sick Asylums (also known as the Workhouse Training Association) was set up in 1879 and began financing nurses' training, following which it 'placed' them in workhouses.[15] The Departmental Committee on Nursing the Sick Poor in 1902 also addressed the shortfall of trained nurses and recommended that individual poor law training schools should be co-ordinated into a national scheme, with major and minor schools providing a three-year or one-year course respectively. The shortened length of training in the minor schools would provide more nurses more quickly with sufficient skills to be competent. One reason for the scarcity was that infirmaries could not attract nurses trained in voluntary hospitals as infirmary nurses were less well paid, worked longer hours and had poorer working conditions than hospital nurses, plus their patients were of a lower social class. All this left poor law nurses with a lower status within the nursing profession.

The main archival source for this chapter was the poor law minutes, which contain greater day-to-day information regarding nursing in Wolverhampton than Birmingham due to the smaller staffing level. In particular, once a trained matron controlled the management of nursing in Birmingham infirmary, much less detail appears in the minutes. This chapter will compare nursing practice at the workhouses

[14] Baly, p.100.
[15] White, p.75.

in Wolverhampton and Birmingham between 1834 and 1914 and contrast the levels of nurse staffing for example to assess the degree to which the number of nurses were sufficient to meet the needs of the increasing number of patients. In the process, it will address the following questions. To what extent were pauper nurses utilised and paid nurses employed, especially in the early decades of the NPL? Was the turnover of nursing staff as high in these two workhouses as has been suggested by other studies and, if so, what were the reasons for their resignations or dismissals? How did the introduction of training influence the standard of nursing care, and what effect did the erection of an infirmary as a separate institution from the workhouse have on the training of probationer nurses? To what extent were men involved in nursing in the workhouse infirmaries and how were they affected by the nursing reforms? Was the reputation of nurses for maltreating their patients justified and to what extent did they exhibit a caring attitude towards their patients? In other words, was Anne Crowther justified in remarking that 'the records of almost any union will produce a dreary tale of nursing inefficiency, neglect and cruelty'?[16] In the process of answering such questions, this chapter will also attempt to draw out the experience of being a poor law nurse in the Victorian period.

Nursing Duties and Recruitment

To understand the level of care a nurse would be able to perform, it is necessary to be acquainted with her previous occupational and social background. Hospital nurses in the early part of the nineteenth century were drawn mainly from domestic servants,

[16] M. A. Crowther, *The Workhouse System 1834*-1929, London, 1983, p.165.

although nursing formed the lowest rung on the domestic service ladder.[17] In voluntary hospitals, sisters, who supervised the nurses, often came from a higher social class, while the matron, topping the nursing hierarchy, originated from an even higher social standing, although was usually employed as a housekeeper rather than a nurse.[18] Paid nurses in workhouses were equivalent to sisters in that they supervised the pauper nurses, but they did not share a common class background. Table 6.1 demonstrates the domestic service backgrounds of applicants for the post of nurse in the female infirmary wards in Birmingham in 1852, with those already employed as nurses the next most common. Surprisingly, one of the two candidates recommended to the board of guardians by the Visiting and General Purposes Committee was Sarah Davis, who had no obvious previous occupation, but they were impressed by her testimonial from a minister of religion.[19] The other was Elizabeth Manton, who was already employed at the workhouse as night nurse and had a testimonial from Mr Humphrey, the workhouse medical officer (hereafter WMO). She had been dismissed from her post of nurse at the workhouse when the guardians reduced the nursing complement and had obtained a post as nurse at the Queen's Hospital in Birmingham, but had subsequently applied successfully for the post of night nurse at the infirmary. She was upgraded to infirmary nurse and Sarah Davis was given her previous post as night nurse, although the latter resigned for unknown reasons seven months later.[20] The majority of candidates were middle-aged, widowed or separated from their husbands, similar to the 11 applicants a decade previously, where only one was a

[17] C. Helmstadter and J. Godden, *Nursing before Nightingale, 1815-1899*, Farnham, 2011, p.10; nurses appointed by nursing associations came from similar backgrounds: S. Wildman, 'Local nursing associations in an age of nursing reform, 1860-1900', (unpublished PhD thesis, University of Birmingham, 2012), pp.143-151.
[18] Ibid., pp.8, 52.
[19] Birmingham Central Library (hereafter BCL), Visiting and General Purposes Committee (hereafter VGPC), GP/B/2/8/1/1, 10 December 1852.
[20] Ibid., 17 December 1852; Birmingham Board of Guardians' minutes (hereafter BBG), GP/B/2/1/12, December 1852; The National Archives (hereafter TNA), MH12/13298, 11 February 1852; MH12/13299, 7 July 1853.

spinster.[21] Nurses appointed at the General Hospital in Birmingham at this time came from similar backgrounds, but this changed in the second half of the nineteenth century, with younger and more unmarried women being appointed, as occurred in other voluntary hospitals.[22] By early the next century, the 11 of the applicants for posts as charge nurses at Wolverhampton workhouse were working as nurses and the other five were not in employment.[23] This recruitment pattern relates to female nurses as nursing was a female dominated occupation and men were rarely employed in voluntary hospitals.[24]

Surprisingly, when 27-year-old Ellen Spencer was appointed as night nurse in Birmingham in 1877, she was described as a 'trained nurse', since training was still in its infancy at that time. Edward Harwood, aged 51 years, who was employed as male nurse the same year, had previously worked as a farmer before posts as porter and nurse in other workhouses.[25] The occupational background of men before they took up nursing was different from women, although John Warder, who was appointed assistant keeper in the insane wards in 1846, had been a gentleman's servant. One of the other two keepers had worked as a butcher and the other as a gunsmith.[26] Thomas Gale, appointed as attendant in the epileptic ward in 1851, had been a corporal in the 54th Regiment of Infantry.[27] The social origins of male keepers were likely to be a reflection of the local employment situation, as was the case for their equivalent in

[21] BCL, House Committee (hereafter HC), GP/B/2/3/1/1, 4 April 1842.
[22] S. Wildman, 'The development of nursing at the General Hospital, Birmingham, 1779-1919', *International History of Nursing Journal*, 4 (1999), pp.21, 24; S. Hawkins, *Nursing and Women's Labour in the Nineteenth Century*, Abingdon, Oxon, 2010, pp.67-68.
[23] WALS, House Committee (hereafter HC), PU/WOL/E/1, 15 June and 5 October 1904.
[24] R. G. S. Brown and R. W. H. Stones, *The Male Nurse*, London, 1973, p.15; C. Mackintosh, 'A historical study of men in nursing', *Journal of Advanced Nursing*, 26 (1997), p.232.
[25] TNA, MH12/13326, 3 March, 13 April 1877.
[26] TNA, MH12/13290, July 1846.
[27] TNA, MH12/13298, 31 December 1851.

lunatic asylums.[28] Between 1881 and 1914, the commonest previous occupations of probationers, who were all female, appointed at Portsmouth and Leeds workhouse infirmaries, other than nursing, were in domestic and personal services.[29] At times, employees performing non-nursing duties in Birmingham workhouse were selected as nurses. For instance, Fanny Giles, who was appointed as nurse of the women's infirmary ward in 1844, had been employed as cook for at least three years beforehand.[30] Domestic tasks formed a major part of a nurse's duties, which Brian Abel-Smith has described as a 'specialised form of charring'.[31] However, Anne Borsay contests this description on the grounds that non-child nursing was being recognised as an activity in its own right by the beginning of the nineteenth century.[32] Nevertheless, responsibility for the good order of the wards and the cleaning not only of the wards, but also of all the rooms and passages of Westminster Hospital, London was included in the nursing regulations in 1835.[33] Carol Helmstadter and Judith Godden have described hospital nurses in the early nineteenth century as 'essentially cleaning women'.[34] Nurses gave minimal personal attention, although they assisted those patients who were required to be in bed by day and those who were unable to wash themselves. In addition, they carried out such treatments as bleeding with leeches, blistering using poultices, which they would prepare themselves, and administering emetics and enemas, all of which required supervision and care of patients for a period following treatment.[35] The PLCs issued a General Consolidated Order in 1847, defining the duties of the nurse as attending upon those in the sick

[28] L. D. Smith, 'Behind Closed Doors; Lunatic Asylum Keepers, 1800-60', *Social History of Medicine*, 1 (1988), p.307.
[29] Maggs, pp.27-28.
[30] BCL, HC, GP/B/2/3/1/1, 28 May 1844; Census Enumerator's Books (hereafter CEB), 1841.
[31] Abel-Smith, p.4; Wildman, 'Local nursing associations', pp151-52.
[32] A. Borsay, 'Nursing, 1700-1830: Families, Communities, Institutions', in A. Borsay and B. Hunter (eds), *Nursing and Midwifery in Britain since 1700*, Basingstoke, 2012, p.39.
[33] Helmstadter and Godden, p.27.
[34] Ibid., p.11.
[35] White, pp.8, 24; Dingwall, Rafferty and Webster, pp.10-11, 55; Helmstadter and Godden, pp.35-37.

wards, administering all medicines and medical applications, as directed by the medical officer (hereafter MO), and ensuring a light was kept at night in the these wards. The only qualification required was the ability to read the directions for giving the medicines.[36]

As was the case with nursing in voluntary hospitals, a workhouse nurse's working life was arduous, with long hours and a requirement to be available both day and night. Living conditions were extremely harsh and many nurses ate and slept in the wards with the patients.[37] However, protests against the poor quality of living accommodation and food were infrequent, but occurred in both voluntary hospitals and workhouse infirmaries.[38] Evidence for the exact tasks they undertook is sparse. In the early nineteenth century, Birmingham guardians' main requirement was that they kept the wards in 'that state of cleanliness which is essential to the welfare of the sick'.[39] In Wolverhampton in 1890, nursing duties still included housekeeping tasks, such as keeping the porter's book in his absence and assisting the matron 'in the stores'. They were also responsible for personally supervising the bathing of all female children prior to examination by the MO.[40] Bathing patients was the activity that took up most of the nurses' time in Birmingham workhouse in 1907.[41] One of their main tasks in the General Hospital in Birmingham was cleaning the wards, although they assisted those patients who needed personal care. By 1878, they were

[36] Ibid., pp.25-26.
[37] Higgs, p.129; Helmstadter and Godden, p.59.
[38] S. Wildman, '''Docile Bodies'' or ''impudent'' women: conflicts between nurses and their employers, in England, 1880-1914', in R. Jutte (ed.), *Medizin, Gesellschaft und Geschichte*, Stuttgart, 2014, pp.13-17.
[39] BCL, BBG, GP/B/2/1/2, 2 June 1818.
[40] WALS, Resolutions passed by the Guardians as to the Duties of Officers, PU/WOL/L, 27 October 1890.
[41] BCL, HSC, GP/B/2/3/3/22, 9 April 1907.

allowed to take patients' temperatures but it was not until the early twentieth century that they had the responsibility for measuring patients' pulse and respiratory rates.[42]

Table 6.1: Applicants for the Post of Nurse in the Female Infirmary Wards at Birmingham Workhouse, 1852

Name	Age	Place of abode[43]	Comments
Ann Jones	35	At Mrs Parsons, Cottage Yard, Hospital Street	Domestic servant Married, but not living with husband, one little girl in service 1 testimonial
Elizabeth Manton	41	At present Night Nurse in infirmary at new workhouse	Widow, no dependent children 2 testimonials, one from Mr Humphrey
Mary Minshull	45	Night Nurse at the General Hospital, which she leaves tomorrow	Widow, no children 4 testimonials, from Dr Wright and others
Elizabeth Withers	57	32 Tark Street	Deserted by husband; 2 children with her, under 12 years of age No testimonials
Margaret Morris	47	22 Latimer Street West	Widow, no family; has been private nurse for years, formerly nurse at Infant Poor Asylum and at Queen's Hospital Testimonial private
May Larkin	52	At Mr Roberts, Kent Street	Widow; 2 daughters, both married; has been cook and house keeper in various private families 4 testimonials, from Lady Sligo and others
Sarah Frances Davis	27	2 House, 24 Court High Street, Bordesley	Married; husband in the 40th Regiment Foot, now in service in Australia; no family 3 testimonials, including one from the Minister of Zion Chapel, Newhall Street

Source: BCL, VGPC, GP/B/2/8/1/1, 17 December 1852.

No information is available on the hours of work in Birmingham or Wolverhampton workhouses in the nineteenth century, but in the latter, nurses were granted leave on one Sunday *per* month in 1870.[44] Early in the twentieth century, nurses were on duty from 7am until 8pm daily except Sunday, when they had leave for half a day once in a month. However, they were only on 'active duty' for two-thirds of this time and for

[42] Wildman, 'Nursing at the General Hospital', p.21.
[43] All addresses were in Birmingham.
[44] WALS, Wolverhampton Board of Guardians minutes (hereafter WBG), PU/WOL/A/14, 18 March 1870.

the remainder, needed only to be on-call on the premises. As a result, their time on active work did not exceed eight hours daily.[45] In the early 1910s, Birmingham guardians admitted that nurses' hours were long, but compared favourably with other infirmaries and the local voluntary hospitals (Table 6.2). Sisters worked from 8am until 1pm, 1.30pm until 4.15pm and 7.15pm until 9.15pm, and had a whole day of leave each month. Nurses worked from 7am until 8.30am, 9.15am until 1.30pm and 4.15pm until 9pm.[46] However, by the following year, sisters' hours had been reduced from 61 and a half to 54 and a half *per* month.[47]

Table 6.2: Weekly Average Hours Worked by Sisters and Nurses in 1911

Infirmary/Hospital	Sisters	Nurses
Birmingham Infirmary	61½	64¼
Marylebone Infirmary	61¾	73¼
Manchester Infirmary	64¾	69¾
Liverpool Infirmary	71¾	74½
General Hospital, Birmingham	56¼	72½
Queens Hospital, Birmingham	61½	61¼

Source: BCL, Infirmary Management Committee, GP/B/2/4/4/6, 27 February 1911.

Nursing Turnover in Wolverhampton, 1839-1890

The high turnover of paid nurses in workhouses, while generally accepted as being the norm, has not received detailed attention in the literature to date and there are no accounts of nurse employment over a continuous time period. In her study of Leicester workhouse, Angela Negrine cites only one example of a brief length of tenure, when five nurses appointed in 1886 all resigned at the same time in the

[45] Ibid., PU/WOL/A/30, 10 October 1902.
[46] BCL, Infirmary Management Committee (hereafter IMC), GP/B/2/4/4/6, 27 February 1911.
[47] BCL, Infirmaries Committee (Hospitals), GP/B/2/4/8/1, 10 September 1913.

following year.[48] The nurse appointed by the Reading Union workhouse in 1870 resigned within days and her replacement was asked to leave within six months, because of inefficiency including giving patients the wrong medication.[49] Furthermore, few accounts of poor law nursing include the early decades of the NPL or attempt to analyse why turnover was so high. It may have been the result of the long hours of work, the heavy workload or the fact that the nurses often ate and slept in the wards with their patients. An additional factor may have been the loss of women to marriage, a feature of women's employment at the time, although the extent of this factor is debatable[50].

Recruitment was not the main problem for the guardians, but retention of the paid nurses they had appointed. Nursing staff turnover was high over the next 50 years, with the guardians needing to employ 18 female nurses (Table 6.3). Excluding Nurse Elizabeth Careless, who remained in post for 26 years, the average length of stay was less than two years. The 19 male nurses and superintendents of the male insane employed over that time had similar lengths of stay of one year and six months and one year and 11 months respectively, but 10 of the nurses were in post for less than a year. The exceptions were the seven superintendents for the female insane who served three years on average (Table 6.4). This contrasts with the tenure of the MOs, which ranged between seven and 22 years after tendering had been abolished in 1841.[51] However, continuity of nursing staff was better than it appears from these

[48] Negrine, pp.106, 111.
[49] M. Railton and M. Barr, *Battle Workhouse and Hospital 1867-2005*, Reading, 2005, pp.37-38.
[50] See Hawkins, pp.141-148 for a discussion of this issue.
[51] See chapter 4, Table 4.3 for further details.

Table 6.3: Nurses Appointed to the Infirmary Wards in Wolverhampton Workhouse, 1839-1890

FEMALE WARDS			MALE WARDS		
Name	Date of Appointment	Length of Service	Name	Date of Appointment	Length of Service
Sarah Keeling	December 1839	6 months	Mrs Poole	May 1856	4 years 2 months
Elizabeth Davies	February 1840	8 months	Edward Shubotham	July 1860	4 years 9 months
Maria Carphew	November 1840	4 years 6 months	Thomas Alldridge	April 1865	1 year 4 months
Jane Frost	May 1845	2 years	William Barley	August 1866	5 months
Elizabeth Careless	August1847	4 years	John Jennings	February 1867	11 months
Mary Ann Sharratt	July 1851	8 months	William Ward	January 1868	8 months
Sarah Cox	March 1852	1 year	William Stokes	September 1868	1 month
Mary Leeson	March 1853	1 year 6 months	Francis Evenson	October 1868	4 months
Martha Gettings	September 1854	7 months	William Ward	February 1869	8 months
Catherine Cox	April 1855	1 year 6 months	Edwin Ladbrook	October1870	9 months
Sarah Mercer	September 1856	c. 3 years 9 months	William Humphreys	September 1871	4 months
Sophia Siddons	mid-1860	c. 2 years	Edwin Ladbrook	February 1872	3 years 3 months
Mrs Shelley	August 1862	3 years 7 months	Joseph Downward	July 1875	3 months
Elizabeth Careless	March 1866	7 years 3 months	Joseph Smith	October 1875	4 years 5 months
Ellen Ward	June 1873	1 year 2 months	Robert Clinton	April 1880	7 months
Mary Wedgebarrow	August 1874	11 months	Llewellin Harris	December 1880	1 year
Mary Daly	July 1875	5 years 2 months	Charles Cattrell	December 1881	2 years 3 months
Elizabeth Clarke	September 1880	1 year 9 months	George Thomas	March 1884	5 years 5 months
Martha Trow	July 1882	1 year 9 months	Samuel Austin	August 1889	Not known
Clara Lyne	March 1884	1 year 3 months			
Sarah Stringer	May 1885	11 years 10 months			

Source: WALS, WBG, PU/WOL/A/2-22, 1839-90.

figures, as many of the nurses appointed were chosen from the superintendents of the insane and their assistants.

Two months after the union workhouse opened in 1839, the guardians advertised for a nurse for the sick, the only requirement being 'persons willing to undertake the situation'. Sarah Keeling was subsequently appointed as 'Head Nurse' at the workhouse at a salary of £12 *per annum*.[52] Within a month they were again

Table 6.4: Appointments as Superintendents of the Insane in Wolverhampton Workhouse, 1861-1890

MALE INSANE			FEMALE INSANE		
Name	Date of Appointment	Length of Service	Name	Date of Appointment	Length of Service
William Parker	January 1861	1 year 4 months	Mary Parker	January 1861	1 year 4 months
Mr Lack	mid-1862	c. 4 years 6 months	Mrs Lack	mid-1862	c. 4 years 6 months
Henry Pretty	February 1867	1 year 3 months	Margaret Yeomans	February 1867	6 years
Mr J. Wright	May 1868	1 year 2 months	Sarah Lowe	February 1873	1 year 4 months
James Akrigg	July 1870	8 months	Mrs Hollowell	May 1874	7 months
Gerard Carroll	March 1871	1 month	Maria Cartwright	December 1874	10 months
Joseph Kenney	April 1871	9 months	Mary Ann Stanley	November 1875	4 years 4 months
Joseph Downward	February 1872	3 years 6 months	Sarah Owen	April 1880	12 years 9 months
Daniel Johnson	August 1875	4 years 8 months			
Richard Owen	April 1880	14 years 4 months			

Source: WALS, WBG, PU/WOL/A/11-18, 1860-1881.

[52] WALS, WBG, PU/WOL/A/2, 3 December and 27 December 1839.

advertising for a nurse and appointed Elizabeth Davies on a trial basis for one month, on an annual salary of £15, prior to a permanent arrangement if found suitable, suggesting Sarah Keeling had not been so.[53] However, by November that year, Davies had been replaced by 35-year-old Maria Carphew.[54] Over the next two years, she was reprimanded over her conduct, on the first occasion for failing to bath a child, as instructed by the WMO, and on the second for being described by him as 'disorderly and riotous in the lying-in ward'.[55] With only one paid nurse in the workhouse, pauper nurses were responsible for delivering babies in the lying-in ward. When Sarah Porter's illegitimate baby died shortly after such a delivery, the subsequent coroner's verdict was that the lying-in ward was 'perversely misconducted'.[56] The pauper nurses in question were deemed no longer fit to carry out such duties, as they had not informed the MO in the Porter case. Despite the master and matron expressing their disquiet at pauper nurses acting as midwives, the guardians took no action.[57] Two years later, the master again reported nurse Carphew for behaving with 'gross indecency' in the lying-in ward and she must have been dismissed or resigned as the records show four applicants for the post.[58] Reasons for nurses leaving or resigning their posts were not recorded for the majority of nurses. However, Edward Shubotham, who resigned in 1865, was on a list of nurses at Birmingham workhouse one year later.[59] A married man in his mid-30s, he had been appointed in May 1860 when the WMO requested the appointment of a male nurse as he would have better control of the male patients, as well as being 'better for the sake

[53] Ibid., 21 February and 15 May 1840.
[54] Ibid., 1 January 1841; CEB, 1841.
[55] WALS, WBG, PU/WOL/A/3, 24 June 1842, 26 May 1843; Master's Journal (hereafter MJ), PU/WOL/U/2, 27 May 1843.
[56] WALS, WBG, PU/WOL/A/4, 7 and 14 July 1843.
[57] WALS, WBG, PU/WOL/A/4, 7 and 14 July 1843; MJ, PU/WOL/U/2, 8 July 1843.
[58] WALS, MJ, PU/WOL/U/2, 3 May 1845.
[59] WALS, PU/ WOL/A/12, 31 March 1865; BCL, VGPC, GP/B/2/8/1/5, 23 March 1866.

of morality'.[60] The guardians questioned whether he would be as sympathetic as a female nurse, to which the MO responded that he had 'never observed sympathy between nurses and patients in public institutions'.[61] Subsequently, men were employed as nurses in the male ward for the next 30 years (Table 6.3).

Two nurses were dismissed for being unable to carry out their duties efficiently. Jane Frost, who had previously been a 'housekeeper for invalids' and a children's nurse, was the first in 1847, after two years of service.[62] At this time, there were 57 patients in the infirmary, infectious disease and lying-in wards, all of which would have been under her care.[63] She wrote to the guardians requesting they reconsider their decision, but they upheld it on the grounds that she was 'far advanced in years' when she was appointed (although only 63 years at the time) and considered that her inability to supervise pauper nurses 'amounted to insubordination'.[64] The guardians decided that her successor 'should be able to write' and appointed Elizabeth Careless, who was in her early 50s.[65] Birmingham guardians elected Catherine Thompson as night nurse in 1852 and, despite declaring that she would not be able to read the directions of the WMO, considered her competent to fulfil the office of nurse. However, the PLB did not sanction the appointment.[66] Wolverhampton guardians dismissed Sophia Siddons in 1860 after a complaint by the MO of her inefficiency, 'harshness' and neglect of 'her duties'. She was given an ultimatum of resigning within the week or being dismissed and chose the former.[67] The following year, she was appointed nurse at

[60] WALS, *WC*, 23 May 1860.
[61] Ibid., PU/WOL/A/11, 11 May, 1 June 1860; CEB, 1861.
[62] WALS, WBG, PU/WOL/A/5, 11 June 1847; TNA, MH12/1167, 16 July 1845.
[63] Ibid., 16 August 1845.
[64] WALS, *WC*, 23 June 1847.
[65] WALS, WBG, PU/WOL/A/6, 16 July and 13 August 1847; CEB, 1851.
[66] TNA, MH12/13298, 22 January, 11 February 1852.
[67] WALS, WBG, PU/WOL/A/11, 4 July 1862.

Dudley workhouse and remained there until her death in 1876.[68] Although she was not dismissed for her inefficiency, Mrs Martha Gettings tendered her resignation in 1855, within seven months of appointment, following investigation into a complaint by Benjamin Lane, an inmate, regarding his medical treatment. The nurse admitted she had failed to carry out the MO's order to apply a poultice to Lane's chest and admitted she had 'a bad memory', which resulted in her frequently forgetting directions.[69] At that time, she had had the assistance of six wardsmen and seven wardswomen, who were provided with a better diet than the other inmates.[70] Surprisingly, Mrs Gettings was among the nine applicants when the post became vacant again in the following year, but was not appointed.[71] Another common reason for dismissal was taking leave without consent and failing to return to the workhouse, as happened with four male nurses during 1868 and early 1869. William Barley, appointed in 1866, was unfortunate to be given one month's notice after only six months in post because he was unable to work due to a chronic leg ulcer.[72] The only instance of nurses returning from leave 'drunk' occurred in 1881 to male nurse, Llewellin Harris, and the assistant superintendent of the male insane, Henry Jenkins, on Saturday and Sunday evenings. Harris was dismissed, but Jenkins was only required to resign.[73]

Another who was coerced into resigning was Joseph Darnward when it was discovered, in October 1875, that he had married Maria Cartwright, the assistant superintendent of the female insane without permission of the guardians; Cartwright

[68] Higgs, p.131.
[69] WALS, WBG, PU/WOL/A/8, 30 March 1855; *WC*, 4 April 1855. For further details of the treatment of Benjamin Lane, see chapters 4 and 5.
[70] Ibid., 29 October 1852.
[71] WALS, WBG, PU/WOL/A/11, 22 June 1860.
[72] WALS, WBG, PU/WOL/A/13, 18 January, 1 February 1867, 3 January 1868.
[73] Ibid., PU/WOL/A/19, 11 November 1881.

resigned a few weeks later. He had been appointed keeper of the male insane inmates three years before and subsequently male nurse only a few months before his resignation.[74] Marriage was also the reason for the resignation of two officers in March 1880, when Daniel Johnson, superintendent of the male insane married Jane Moore, assistant superintendent of the female insane. The Johnsons were re-employed as a married couple in charge of temporary workhouse accommodation. Joseph Smith, the male nurse of over four years standing, and Mary Stanley, the recently appointed superintendent of the female insane, also resigned on exactly the same date, though the reasons were not recorded in the minutes. Mrs Stanley, a widow in her early 40s, was re-employed six months later as the assistant in the female insane wards.[75] Men, as well as women, were required to resign on getting married, as nurses were required to live in the workhouse and had very little leave. The only opportunity for a married couple was joint employment, for instance William and Mary Parker, husband and wife in their early 40s, appointed in January 1861 as superintendents of the male and female insane respectively.[76] They resigned 16 months later to become master and matron of another workhouse.[77] Their successors as superintendents of lunatics, Mr and Mrs Lack, resigned when he was appointed 'Collector of Local Rates' for Wednesfield Heath.[78] Thirteen years later, another married couple, Richard and Sarah Owen, were chosen as superintendents of the insane. When Mrs Owen died in 1893 in her mid-50s, her husband continued in his post.[79] In 1873, Mrs Elizabeth Careless retired in her 80th year as nurse in the female infirmary, suffering from 'partial paralysis'. She had been an officer in the

[74] WALS, WBG, PU/WOL/A/16, 13 August, 1, 22 October 1875.
[75] Ibid., PU/WOL/A/18, 19, 25 March, 23 April, 24 September 1880.
[76] Ibid., PU/WOL/A/11, 11 and 18 January 1861.
[77] Ibid., 9 and 23 May 1862.
[78] Ibid., PU/WOL/A/12, 25 January, 8 February 1867.
[79] Ibid., PU/WOL/A/18, 2 April 1880; PU/WOL/A/24, 12 January 1893.

workhouse since 1847 and had also worked briefly on the fever ward (during the smallpox epidemic in 1849) and as matron's assistant. The guardians approved a superannuation allowance of £20 *per annum.*[80]

Catherine Cox, appointed nurse in the female infirmary in 1855, resigned after her request for an increase in her annual salary of £15 after 18 months in post was refused.[81] The female nurse's salary was increased to £20 seven years later and Thomas Alldridge, the male nurse, had his annual salary increased in 1865 to £30, after dispensing had been added to his other duties.[82] In light of the difficulties in retaining nursing staff at that time, one of the guardians, Mr Sidney, intended to propose a motion to replace pauper nurses with paid employees. Regrettably, he died before he could bring the motion before the board.[83] Two years later, the WMO suggested that all the nurses should be paid, but the master judged the nursing situation satisfactory 'considering the class of nurses employed'. The guardians took no action, as appointing extra nurses would involve providing extra accommodation for them.[84] Around this time, recruitment of nursing staff began to be problematic. When Edwin Ladbrook, who had commenced work in October 1870, resigned nine months later, the guardians had no response to their initial advertisement for his replacement, but were able to appoint William Humphreys two months later.[85] When he contracted smallpox the following year, the master was unable to find a temporary replacement, but he recovered and resumed his duties after a few weeks.[86] Four years later, the guardians adopted a new schedule of officers' salaries, after obtaining

[80] Ibid., 13 June 1873; *WC*, 18 June, 30 July 1873.
[81] WALS, WBG, PU/WOL/A/9, 12 and 19 September 1856.
[82] WALS, WBG, PU/WOL/A/12, 4 August 1865; *WC*, 19 April 1865.
[83] Ibid., 24 April, 17 July 1868.
[84] WALS, *WC*, 6 July 1870.
[85] Ibid., 25 August, 8 September 1871.
[86] WALS, WBG, PU/WOL/A/15, 29 December 1871, 5 January 1872.

information from 47 other unions. This involved increasing the starting salaries by an increment of £1 every second year to a fixed maximum, obviating the necessity for officers to apply at intervals for an increase (Table 6.5).[87] The maximum salaries differed little from those they were paying at the time and were in line with wages in other poor law institutions and in the General Hospital, Birmingham.[88] Although the guardians paid the superintendents of the insane the same wages as the nurses, they disagreed with the LGB that they were on 'the same footing' as the nurses, as they did not consider they performed nursing duties.[89] In the early 1880s, there were 27 applications for the post of male nurse and 13 for that of assistant superintendent of the male insane, demonstrating that recruitment was no longer a difficulty and it would remain as such throughout that decade.[90]

Table 6.5: Salary Schedule for Officers in Wolverhampton Workhouse, 1876

Officer	Present Annual Salary	Minimum Salary	Maximum Salary
Male nurse	£30	£30	£35
Female nurse	£25	£20	£25
Superintendent of male insane	£30	£30	£35
Superintendent of female insane	£30	£25	£30
Assistant superintendent of female insane	£26	£20	£25

Source: WALS, WBG, PU/WOL/A/16, 11 February 1876.

At the time the workhouse opened, the nursing staff had consisted of only one nurse, until 1856, when a second was appointed. Two superintendents of the insane were added to the nursing complement 11 years later and two assistant superintendents five

[87] Ibid., PU/WOL/A/16, 11 February 1876.
[88] White, p.74; Wildman, 'Nursing at the General Hospital', p.22.
[89] WALS, WBG, PU/WOL/A/18, 18 June 1880.
[90] Ibid., 2 February 1882.

years after that. By comparison, inmates had increased from just over 300 to almost 1,000 and patients from 55 in 1842 to 423 in 1888.[91] In 1874, one of the guardians considered it a disgrace that there was only one female paid nurse, Mrs Mary Wedgebarrow, as she had over 100 sick inmates under her care.[92] The two nurses employed to care for patients with physical illness saw their patients increase from 87 each in 1866 to 157 each 22 years later.[93] There is no evidence from Wolverhampton that the increasing number of sick inmates influenced length of service, as there was a tendency for nurses to stay in post longer after 1880. Nor were the salaries a deterrent, as they were comparable to most other medium-sized and large workhouses in the third quarter of the century.[94] Of those who resigned, only a few took up nursing posts elsewhere and a substantial proportion may have done so out of a dislike for the type of work they were required to carry out.[95] The impact of loss due to marriage would have been lessened to a degree in Wolverhampton by the guardians' preference for appointing older widows, and male nurses left employment after a short period as frequently as their female counterparts. A major factor causing the high turnover was the exhausting nature and the demanding pace of the work, which applied also to nursing in voluntary hospitals. For instance, the average length of stay of seven nurses at St Thomas' Hospital in 1847-48 was eight weeks.[96]

[91] WALS, MJ, PU/WOL/U/2, 16 April 1842; WBG, PU/WOL/A/22.
[92] WALS, WBG, PU/WOL/A/16, 31 July, 21 August 1874; *WC*, 17 February 1875.
[93] BPP, 1867-68 (4), p.153; WALS, *WC*, 11 July 1866 and 4 April 1888; WBG, PU/WOL/A/22, 6 April 1888. The figures are not directly comparable, as the first excludes those 'of unsound mind' from the patient total, and the second 'idiots and imbeciles', but they give a fair estimate of the increase in the nurses' workload.
[94] White, pp.26, 74.
[95] Maggs, 'Nurse Recruitment', p.33; he found that 16% of probationers in the early twentieth century left their training early for this reason.
[96] Helmstadter and Godden, pp.53, 188, 191.

Paying Nurses and Paupers in the First Birmingham Workhouse

Although the NPL facilitated the employment of paid nurses, many boards of guardians were slow to implement the new arrangements while some large workhouses included remunerated nurses among their servants under the Old Poor Law arrangements. In 1818, Birmingham guardians gave the surgeons they employed instructions to appoint 'one chief nurse' to each ward in the Town Infirmary and resolved that the nurses were to be 'entirely under the direction of the Surgeons'. Furthermore, each nurse would be allowed as many assistants as was necessary from among the female paupers in order to keep the wards clean.[97] Five years later, they increased the nurses' salaries to 2s 6d and the assistants to 1s per week when they discovered the 'pernicious custom' of the nurses receiving gratuities from patients due to the inadequacy of the salaries.[98] The nurses' annual pay of £6.10s was better than that of £4.13s paid to the nurses at the General Hospital in Birmingham at that time.[99] The nursing arrangements continued unchanged after 1834, but in 1842, they advertised for 'several females as nurses in the Town Infirmary', with the requirements that the women were 'of good character, of assiduity and determination, and possessed of kind feelings towards sick patients'.[100] The House Committee interviewed 11 applicants, some of whom were already employed, while others were pauper nurses. For instance, Elizabeth Higgs, a pauper nurse, who was 41 years of age and had a boy in the guardians' facility for pauper children, was continued as nurse in the lying-in ward at an annual salary of £10. Ann Rose, a spinster aged 46 years, remained as nurse of the old and infirm women's wards on £8 per annum. Six other appointments, all widows, were made to the infirmary wards, women's fever,

[97] BCL, BBG, GP/B/2/1/2, 11 February 1818.
[98] Ibid., 1 July 1823.
[99] Wildman, 'Nursing at the General Hospital', p.22.
[100] BCL, HC, GP/B/2/3/1/1, 29 March 1842.

venereal and insane wards and the bedridden ward. The annual salaries ranged from £8 to £13 and the nurses were allowed a ration of tea, sugar and butter.[101]

The matron was instructed to appoint fit, able-bodied women as assistants, but the house surgeon considered only Elizabeth Harrington, a widow 'with no encumbrances' competent to perform the duties required. In addition, he pointed to the need for night nurses, as many of the more disabled patients required as much attention at night as by day.[102] Mary Mills, aged 22 years, who was retained as nurse in the women's fever ward, was later considered to be too young after accusations of her misbehaviour with William Purnell, the male nurse on the fever wards. As a pauper, she could not be dismissed, but was transferred to duties elsewhere in the workhouse. Purnell was retained, although, one month later, he was dismissed for further misconduct.[103] Table 6.6 shows those acting in nursing roles in August 1842 and nearly all the non-pauper nurses were employed on the female side, while some of the male wards, for instance, venereal, did not have any pauper assistance. It is also interesting to note that Elizabeth Higgs' payment had been reduced by half. Three years later, the guardians appointed midwives for the districts and one, Mrs Edge, was also required to attend midwifery cases in the workhouse on the payment of 4s per case.[104] Elizabeth Vincent, a widow aged 37 and nurse in the women's infirmary ward in August 1842, resigned in July the following year, was re-appointed to the same post in the following April, but resigned a month later to become Matron

[101] Ibid., 5 April 1842.
[102] Ibid., 5 April, 7 June 1842.
[103] Ibid., 14 June, 5 July, 19 July 1842.
[104] BCL, BBG, GP/B/2/1/5, 8 July 1845; for a discussion of midwifery in Birmingham workhouse at this time, see F. J. Badger, 'Delivering maternity care: midwives and midwifery in Birmingham and its environs, 1794-1881', (unpublished PhD thesis, University of Birmingham, 2014), pp.232-35.

of the Lying-in Hospital at Islington in London.[105] The clinical activity, for which the seven paid nurses and 14 paupers acting in a caring role were responsible, involved 264 admissions to the Town Infirmary in the relevant quarter of 1842, with 158 in-patients on average.[106]

In July of the same year, the PLCs advised the guardians that paying gratuities to inmates for employment appeared to be an illegal charge on the poor rates and recommended the practice cease forthwith.[107] The guardians reviewed a list of 15 'servants employed' in nursing duties, which included those classed as both paupers and non-paupers (Table 6.6). They had been receiving salaries ranging from £8 to £20 yearly. The guardians resolved that inmates who were employed in tasks in the workhouse should receive extra rations of meat at dinner and a daily beer allowance, presumably instead of monetary remuneration.[108] However, four years later, the allowances for pauper assistant nurses were reduced to the ordinary diet of the workhouse, plus one pint of tea with bread and butter twice daily.[109] This decision may have been the consequence of new and replacement appointments increasing the nursing establishment to 19, of which only seven had remained in post from 1842. They included a few who had been pauper nurses in that year, but as they were continuing to receive an annual salary, would now be designated as officers.[110] At this time, the daily number of inmates varied between 470 and 500, with around one-third needing medical attention.[111] Taking into consideration only those nurses directly involved with sick inmates and lunatics reveals that there was one nurse for

[105] BCL, HC, GP/B/2/3/1/1, 11 July 1843, 16 April, 28 May 1844.
[106] BCL, BBG, GP/B/2/1/4, 11 October 1842.
[107] Ibid., 31 July 1845.
[108] Ibid., 14 August 1845.
[109] Ibid., 26 June 1849.
[110] Ibid., GP/B/2/1/6, 24 April 1849.
[111] Ibid., 9 April to 24 December 1849.

every 11 patients. This was similar to the situation at the General Hospital in 1851, with 220 beds and 17 nurses, giving a ratio of 1 nurse to 13 beds.[112] Despite the greater number of nurses to care for patients in Birmingham workhouse, staff turnover appears almost as high as in Wolverhampton, although fewer were dismissed for misconduct. The misbehaviour of the two nurses in the fever wards has already been

Table 6.6: Paid and Pauper Nurses in Birmingham Workhouse, 1842

Name	Position	Salary
Ann Howlett	Nurse in men's infirmary	£10 per annum
Elizabeth Vincent	Nurse in women's infirmary	£10 per annum
Mary Ann Raven	Nurse in women's bedridden ward	£8 per annum
Elizabeth Line	Nurse in women's venereal ward	£8 per annum
Ann Titley	Nurse in women's insane ward	£10 per annum
Ann Rose	Nurse in aged and infirm women's ward	£8 per annum
Thomas Lamb	Assistant keeper in men's insane ward	£8 per annum
Joseph Gregory	Attendant in men's venereal ward	1s per week
Joseph Galey	Night attendant in men's sick ward	1s 9d per week
George Baker	Attendant in men's fever ward	1s 6d per week
Isabella Taylor	Nurse in women's fever ward	£1 10s per quarter
Elizabeth Higgs	Nurse in lying-in ward	£1 5s per quarter
William Ware	Keeper in men's insane ward	4s 6d per week
Catharine Tipton	Nurse in children's ward	1s per week
Mary Johnson	Nurse in women's insane ward	£1 7s 6d per quarter
Elizabeth Atherley	Nurse in women's day-room	1s per week
Maria Horton	Nurse in old and infirm men and boy's rooms	£1 5s per quarter
William Percival	Wardsman to able-bodied men	1s per week
Joshua Haywood	Wardsman to partially disabled men	1s per week
Mary Knight	Nurse in children's ward	1s per week
Stephen Bridge	Leech bleeder	1s per week
John Dawson	Leech bleeder	1s per week
M A Harriman	Assistant to nurse Rose	5s per quarter
Isabella Taylor, jun.	Assistant to nurse Johnson	5s per quarter

Source: BCL, House Committee, GP/B/2/3/1/1, 9 August 1842; BPP, 1843 [491], pp.139-40. The first seven names are officers and the remainder are paupers.

[112] Wildman, 'Nursing at the General Hospital', p.24.

mentioned and, two years later, Mary Williams and William Fitzer, both nurses in the fever wards, were dismissed because of 'gross misconduct'.[113] Of the other dismissals, George Bates had used violent language when intoxicated; the nurse in the women's sick ward was declared inefficient by the WMO; Charlotte Greasley had acted 'most improperly' to her patients on the female venereal ward; and two nurses were dismissed in 1849 without reasons being recorded.[114] Ann Rose, the nurse in the old women's ward, was reprimanded for selling the tea, sugar and butter provided for the inmates, but resigned of her own accord.[115] However, these incidences involved a very small proportion of the total nursing staff over 16 years. With further resignations and the release of three nurses, the nursing complement was reduced to seven nurses, including one night nurse, plus one 'Insane Keeper' in early 1851. Only four nurses in employment two years before had been retained, indicating a high turnover of staff in a short period of time.[116]

Maintaining Nursing Care in the Second Birmingham Workhouse

The smaller number of nurses was unlikely to be able to cope with the increasing incidence of sickness among paupers in the expanded new Birmingham workhouse. Three months after it opened in 1852, eight paid nurses were providing care but this was increased by three, a few months later, when the children were transferred to the workhouse from the Asylum for the Infant Poor.[117] When Charlotte Davis, nurse in the women's 'sick ward' resigned four years later, Fanny Giles, a nurse on the

[113] BCL, HC, GP/B/2/3/1/1, 2 January 1844.
[114] Ibid, 13 June 1843, 26 March; BBG, GP/B/2/1/5, 3 February 1846; GP/B/2/1/6, 29 May 1849.
[115] BCL, HC, GP/B/2/3/1/1, 5 November 1844, 26 February 1845.
[116] BCL, BBG, GP/B/2/1/7, 19 March 1850; CEB, 1851.
[117] BCL, BBG, GP/B/2/1/11, 16 June, 22 September 1852.

equivalent male ward, was put in charge of both, a move that was challenged by the PLB. However, the guardians defended the action by claiming she could manage both wards efficiently and the PLB sanctioned it for a period of six months, following which the board expected a report on her performance.[118] Perhaps it was this issue that prompted the guardians to request the clerk to ascertain staffing levels and salaries from other workhouses built to accommodate 1,000 inmates or more (Table 6.7). As Birmingham came out well, no changes were made.[119] A further comparison of nursing standards is possible from the survey conducted by Edward Smith, MO to the PLB, of 40 metropolitan and 48 provincial workhouses in 1866-67.[120] He commented that the appointment of paid nurses had been generally accepted as appropriate, as only four workhouses in the capital were without them. Furthermore, the WMOs found pauper nurses 'old, ill-trained and unreliable', necessitating salaried nurses.[121] The provinces fared less well, as 11 workhouses had no paid nurses, but these were usually the smaller institutions, with less than 100 beds.[122] The ratio of the number of inmates on the MOs' books to that of paid nurses at the time of the visit varied greatly, from 15 patients to one nurse to as high as 255 in London and between 4 and 132 in the rest of the country. Paradoxically, the workhouses where few nurses were employed produced the highest ratios in London, but the lowest in the provinces, as this occurred in the smallest workhouses, usually with fewer than 150 inmates.[123] The ratios available for the workhouses in Table 6.7 are: Birmingham 26 (22 nurses for 582 patients), City of London 17, Greenwich 98, Lambeth 166, Leicester 14, Liverpool 38, Manchester 59, Marylebone Street 22, Nottingham about 75 and

[118] Ibid., GP/B/2/1/18, 7 May, 16, 23 July 1856.
[119] BCL, Returns relating to the numbers of Officers and Servants, GP/B/16/2/1, 15 October 1856.
[120] BPP, 1866 (372); 1867-68 (4).
[121] BPP, 1866 (372), pp.23-24.
[122] BPP, 1867-68 (4), pp.26-157.
[123] Ibid.; BPP, 1866 (372), pp.24, 31-32.

Table 6.7: Paid Nurses in Selected English Workhouses, 1856

Union/Parish	Capacity: number of inmates	Nursing Staff	Salary range
Birmingham	1,663	12 nurses 1 attendant on epileptic ward	£6-£26
Bethnall Green	1,016	2 nurses	£15-£20
City of London	1,010	1 superintendent nurse 2 nurses	£20-£31
Clifton	1,180	4 lunatic keepers	£13-£23
Greenwich	1,044	18 paid nurses	Not recorded
Lambeth	1,100	1 nurse	£50
Leicester	1,000	2 nurses 2 attendants on insane	£15-£20
Liverpool	2,345	4 nurses 1 superintendent of lunatics	£12.10s-£20
Manchester	2,000	12 nurses	£2.12s-£22
Marylebone St.	2,000	1 head nurse 1 midwife 11 nurses	£6-£50
Nottingham	1,150	3 nurses	£20-£31.4s
Portsea Island	1,150	1 matron of hospitals 1 nurse 2 keepers of lunatics	£5.4s-£40

Source: BCL, Returns relating to the number of Officers and Servants, GP/B/16/2/1, 15 October 1856.

Portsea Island 49.[124] Birmingham came out best in terms of paid nurse staffing of the provincial workhouses with more than 500 inmates and only three London workhouses were better staffed. Nursing numbers in Birmingham had risen to 13, but pauper help was still being used, with 45 assisting in the infirmary wards by day and 15 at night, so relieving the paid nurses of household tasks, such as cleaning the wards.[125] The contrast with Wolverhampton is stark, with four paid nurses, 238 patients and a ratio of one nurse to 60 patients, with only eight provincial workhouses having a higher rate. Smith found it impossible to believe that the number of paid

[124] Ibid.; Smith noted the nursing experiment using trained nurses was taking place at the time of his visit and gave it a favourable mention.
[125] BCL, VGPC, 2/8/1/5, 25 March 1866.

nurses was sufficient, with two nurses for around 160 cases of 'ordinary sick' and two attendants for nearly 70 lunatics.[126]

Despite Birmingham's level of nurse staffing being among the best in the country, the guardians became concerned in 1874 over the large number of resignations by nurses. They consulted one nurse, Martha Gilbert, and the master and decided there was no one particular reason, but it was possible that the salaries they were offering were lower than in other poor law institutions. Furthermore, there was by this time more alternative nursing work as the town had around seven voluntary hospitals. They requested information from six large workhouses and subsequently increased salaries by between £2 and £7, with the largest increase for those on night duty (Table 6.8).[127] These salaries were in line with those at the General Hospital in the 1870s, where a Head Nurse received between £20 and £25 and an Under-Nurse £13 and £18.[128] However, some nurses remained loyal to the workhouse for many years. When Jane Smith, nurse in the female bedridden ward, was forced to resign because of long-standing ill health and 'advancing age' (although only in her mid-fifties), she was granted 'an annual emolument' of £40 in light of her 25 years' service.[129] In late 1877, a sub-committee was set up to consider the medical and nursing arrangements in the workhouse. On the MO's advice, the sub-committee recommended appointing additional nurses for the female venereal ward, female bedridden ward, male infirmary and the male and female epileptic wards. Members of the inquiry agreed to

[126] BPP, 1867-68 (4), pp.152-53.
[127] BCL, House Sub Committee (hereafter HSC), GP/B/2/3/3/4, 17 November 1874, 9 February, 23 February 1875.
[128] Wildman, 'Nursing at the General Hospital', p.22.
[129] BCL, HSC, GP/B/2/3/3/5, 18 April 1876; the amount was based on her salary, plus a notional amount for board and lodgings.

recommend appointing a superintendent of the nursing staff, who would be 'well qualified by training and education' and who would supervise the 'whole of the

Table 6.8: Increases in Annual Salaries for Nurses in Birmingham Workhouse, 1875

Nurse's department	Annual Salary	
	Before Increase	After Increase
Female bedridden	£20	£25
Male infirmary	£18	£20
Female infirmary	£18	£20
Fever ward	£21	£24
Lying-in ward	£22	£25
Female epileptics	£18	£20
Venereal ward	£15	£20
Old women's ward	£18	£20
Nights	£15	£22

Source: BCL, House Sub Committee, GP/B/2/3/3/4, 23 February 1875.

Nursing of the Sick', despite the senior MO's view that a professional nurse was not necessary. Kate Nicholson, who was in her mid-20s and younger than most of her nursing staff, was appointed to the post in the following year.[130] However, turnover of staff remained high, with 21 nurses and attendants leaving over a 15-month period out of a nursing establishment of 28. Two were dismissed for misconduct and two men because they were married, the guardians preferring single men. As a result, Edward Marshall was replaced by 31-year-old Samuel Bradburn, who had worked as a nurse at Manchester and Sheffield Unions after a period as a rubber worker.[131] Edward Riley, nurse in the male surgical and venereal wards, resigned in December 1881 because the work was 'too much' for him.[132] Thirty years before, William Key, attendant on the male epileptic ward, resigned in similar circumstances as he found

[130] BCL, Workhouse Inquiry Sub Committee, GP/B/2/3/11/1, 23 March 1878; VGPC, GP/B/2/8/1//7, 3 May 1878; BBG, GP/B/2/1/46, 31 July 1878; CEB, 1881.
[131] TNA, MH12/13336, 31 January 1881.
[132] TNA, MH12/13338, 15 December 1881.

the 'confinement prejudicial to his health', and joined Birmingham police force.[133] The most common reasons for female nurses resigning in 1880-81 were to get married and to join or accompany their husbands (Table 6.9).[134] Thus marriage was an important factor in the loss of nurses, at variance with Sue Hawkins' claim that it was not a significant drain on nursing departments based on finding less than 3% annually resigning for this reason at St George's Hospital, London.[135] Despite the WMO's and Nicholson's request for more nursing staff, the guardians agreed only to a temporary increase in staff, as the number of sick inmates had 'considerably decreased'.[136] However, the following year, Nicholson managed to get the newly constituted 'Infirmary Sub Committee' to agree to five additional nurses for the male and female surgical wards, the male venereal ward and for night duty on the male and female epileptic wards. The committee also agreed to provide uniforms for nursing staff, as a means of controlling the spread of infection during the current smallpox epidemic, although it is not clear if this was a temporary measure. However, when probationers were appointed for the first time a year later, uniforms, consisting of print dresses, aprons, collars and caps, were provided, but were only supplied after probationers had completed their trial period of four weeks. Assistant nurses and charge nurses were also provided with uniforms that would distinguish their grade from each other and from the probationers.[137] In 1899, Wolverhampton guardians were spending around £80 annually on uniforms.[138] The appointment of probationers in Birmingham increased the nursing staff to 37, although the number of patients had remained

[133] TNA, MH12/13298, 31 December 1851.
[134] BCL, VGPC, GP/B/2/8/1/8, 28 October 1881; CEB, 1881.
[135] Hawkins, p.148.
[136] Ibid., 25 November 1881.
[137] BCL, Infirmary Sub Committee (hereafter ISC), GP/B/2/4/1/1, 28 July 1882; GP/B/2/4/1/2, 2 November 1883; GP/B/2/4/1/4, 6 January 1888.
[138] WALS, WBG, PU/WOL/A/28, 9 March 1900.

static.[139] Although pauper nurses were still employed at night, the main duties were keeping the fires burning, giving ordinary drinks to patients and being present on the wards while the night nurses undertook rounds.[140] At the end of 1885, the guardians took the unusual step of appointing Lydia Rogers as 'Head Night Nurse'. She was a 28-year-old unmarried nurse working in St Bartholomew's Hospital in London before her appointment in Birmingham.[141]

Between 26 January and 11 March 1889, 33 nurses were transferred to the new infirmary, as the relevant patients were gradually moved.[142] However, not all patients were transferred and those with venereal disease and in the bedridden wards remained in the workhouse. Similarly, chronic and venereal patients were not transferred from the body of Blackburn workhouse to the new hospital wards in 1888.[143] John Pickstone claims that the exclusion of patients requiring careful and intensive nursing from the 'hospital section' of the workhouse was common.[144] When a nurse in the workhouse died two years later, the master, supported by the matron and medical officer, claimed three other nurses were incompetent and 'not fit to trust old people with'. They requested that trained nurses be appointed in their place, to which the guardians agreed, but decided to advertise for 'attendants trained in nursing, ages not to exceed 35 years'.[145] Within two months, the master complained that none of the newly appointed 'attendants' would remain long in post unless they were placed on the same footing as the nurses in the infirmary, with their better diet and other

[139] BCL, BBG, GP/B/2/1/51, 12 December 1883.
[140] BCL, ISC, GP/B/2/4/1/1, 3 October 1884.
[141] TNA, MH12/13349, 3 December 1885.
[142] BCL, GP/B/(ACC 2009/109), box 15.
[143] J. V. Pickstone, *Medicine and Industrial Society*, Manchester, 1985, p.217.
[144] Ibid.
[145] BCL, HSC, GP/B/2//3/2/12, 23 June 1891; Workhouse Management Committee (hereafter WMC), GP/B/2/3/2/1, 10 July 1891.

Table 6.9: List of Nurses and Attendants Leaving Office in Birmingham Workhouse, July 1880 - October 1881[146]

Name	Designation	Reason for resignation
Gibbons, E G	Nurse	Dismissed for misconduct
Phillips, Julia	Nurse on lock ward	To join husband
Madden, Sarah	Temporary nurse	Incompetent
Bebbington, George	Attendant aged men's ward	Services dispensed with as they were married and single men were preferred
Marshall, Edward	Male nurse	
Spencer, E	Nurse	To get married
Burley, M	Night nurse	To join husband
Florence Petty	Nurse	To join husband
Rich, M	Nurse	To get married
Launsbury, M	Nurse	To get married
Edward, E	Night nurse	Misconduct
Hudson, MA	Nurse	To get married
Hadew, M	Nurse	Given notice
White, George	Attendant, aged men's ward	Given notice
White, E	Nurse	Resigned with husband
Astley, E	Nurse	Resigned with husband, (tramp master)
Bradburn, S	Male nurse	Obtained more lucrative situation
Tulkington, Fanny	Nurse	LGB refused to ratify appointment
Wiggett, Caroline	Nurse	Resigned with husband (watchman, opening own business)

Source: BCL, VGPC, GP/B/2/8/1/8, 28 October 1881.

privileges. The guardians approved this request and also reverted to the designation of nurses.[147] In the early twentieth century, the post of assistant matron at the workhouse was advertised as requiring a qualified nurse and attracted 45 applications. Emma King, the assistant matron at West Ham Workhouse, was appointed with an annual salary of £50, increasing over five years to £60.[148] She died two years later of typhoid fever despite being admitted to the infectious disease hospital and was

[146] Three other nurses resigned, but no reason was given.
[147] BCL, HSC, GP/B/2/3/3/13, 8 September 1891.
[148] BCL, WMC, GP/B/2/3/2/4, 4 May, 29 June 1906; HSC, GP/B/2/3/3/22, 26 June 1906.

succeeded by Maud Plant.[149] However, the appointment of a trained nurse as assistant matron did not mean that nursing in all the workhouse wards was of a high standard. Mr E. B. Wethered, a LGB Inspector, was critical of the fact that only one nurse was employed on each of two of the female bedridden wards, with 34 patients in each ward who were 'actually bedridden'. He considered there should be seven nurses on each ward to prevent the pauper assistants from having to perform nursing duties.[150]

The chronic nature of the majority of the patients in the workhouse may have contributed to the paucity of nurses and the difficulty with their retention.[151] Several historians have commented on the less interesting nature of patients with chronic disability and the restricted variety of illnesses that their nurses experienced.[152] Concurrent with the development of scientific medicine, there arose the view that the 'chronic sick' did not need skilled nursing.[153] However, Anne Gibson, in her evidence to the Departmental Committee enquiring into the Nursing of the Sick Poor in Workhouses, stated that the 'nursing of the chronic and aged sick' was most important, 'one of the highest and best proofs of a good nurse that she is able to deal with that type of care'.[154] Unfortunately, she had authority only over nursing in the infirmary and not in the workhouse itself.

[149] BCL, WMC, GP/B/2/3/2/5, 10 January, 5 February 1908.
[150] Ibid., GP/B/2/3/2/6, 16 June 1911.
[151] The extent of the chronic disease and the level of disability among workhouse inmates is analysed in chapter 2.
[152] For example, Crowther, p.188; A. Digby, *Pauper Palaces*, London, 1978, p.172.
[153] White, pp.198-99.
[154] BPP, 1902 [Cd. 1367], p.56.

Introducing Nurse Training into Workhouses.

The earliest attempt to provide formal training to pauper nurses was made by the Epidemiological Society in the mid-1850s, with the award of certificates for satisfactory completion (see Appendix E). It foundered because of the inability of the inmates to benefit from training and the opposition of Florence Nightingale. The introduction of trained nurses at Liverpool Union's infirmary, Brownlow Hill, was led by Agnes Jones, Florence Nightingale's 'best pupil', and they were employed to work on the male wards only.[155] They were funded for three years by a local merchant and leading nursing reformer, William Rathbone, who had been dissatisfied with the standard of nursing he had encountered on his visits to workhouses and approached Nightingale for assistance. One year after their introduction, the workhouse master reported a marked improvement in the standard of nursing and rehabilitation of the patients, and a better demeanour among the male patients. The visiting physician preferred the new system as it convinced him of the nurses' ability to implement medical orders, as well as promote good morale on the wards.[156] Although the scheme foundered after Jones' death from typhus in 1868, similar training initiatives were subsequently set up at Highgate by St Pancras Union and at St Marylebone Union in London with funding from the Nightingale Fund.[157]

However, trained nurses could not be employed without the supervision of an officer who had undergone training. Such appointments were facilitated by an LGB order of 1897, which required the appointment of a superintendent nurse, who had undergone three years' training, in any workhouse where three or more nurses were employed

[155] Abel-Smith, p.40.
[156] White, pp.33-34; BPP, 1867-8 (4), p.112.
[157] Baly, pp.90-100.

and that matrons in the separate infirmaries be trained nurses and have overall control of the nursing staff. Five years after the appointment of a superintendent of nurses at Birmingham workhouse in 1878, three probationer nurses were appointed at an initial annual salary of £10, increasing over three years to £18, plus the provision of a uniform. The superintendent, Kate Nicholson, suggested that those who passed the MO's examination, which consisted of a written paper and *viva voce*, should be rewarded by being appointed to the first substantive nursing post to become available.[158] More probationers were taken on over the next four years and, in November 1887, their number was increased to 20 in light of the anticipated opening of the new infirmary and the total abolition of pauper nursing.[159] The guardians sought the LGB's permission to engage up to 20 staff nurses (annual salary, £20-£25), 10 assistant nurses (£20), and 50 probationers (£10-£18) in the new infirmary with a total bed complement of 1,665.[160]

They appointed as matron Miss Annie Gibson, who held the appointment of superintendent at Brownlow Hill Infirmary in Liverpool and was, therefore, one of Agnes Jones' successors. She was paid £130 *per annum* and given the remit to 'take control of the sick in the wards' under the supervision of medical staff and to maintain good order among the nurses and inmates.[161] According to Rosemary White, Gibson became a powerful figure, with well-considered ideas, and one of the most influential members of the poor law medical service.[162] She instigated a scheme for training paying probationers within the infirmary and the fee per trainee of £28 *per annum* generated £900 in revenue for the guardians in 1893, with up to 25 pupils at a time

[158] BCL, ISC, GP/B/2/4/1/2, 2 November, 6 December 1883; GP/B/2/4/1/4, 18 May 1888.
[159] Ibid., GP/B/2/4/1/4, 4 November 1887.
[160] BCL, IMC, GP/B/2/4/4/1, 21 December 1888.
[161] Ibid., 17 August 1888; BBG, GP/B/2/1/57, 29 June, 19 September 1888.
[162] White, pp.96, 100.

undergoing training.[163] As a result, assistant nurses were no longer employed, with charge nurses increased by two to 22.[164] Gibson may have obtained the idea for the scheme from that of the Nightingale school in London in the late 1860s as she had trained at St Thomas' Hospital, where women from the higher social classes could pay for training. It was these 'lady-pupils' who later were at the forefront of reform.[165] By 1896, Birmingham infirmary was training 32 paying probationers. In a return of nursing staff in workhouses in England and Wales in 1896, Birmingham was the only one that declared additional fee-paying nurses and it is likely the scheme was unique within the poor law nursing service, although a similar scheme had been in operation at the General Hospital for at least two decades.[166] Of the 73 paid nurses, 35 had received training prior to their appointment, in contrast to Wolverhampton workhouse, where none of the three nurses, caring for 165 sick and bedridden inmates, had received prior training and where 43 inmates assisted in the personal care of patients.[167] The nurse-to-patient ratio in Birmingham infirmary was 1:13, compared with 1:55 in Wolverhampton workhouse. In Birmingham, it was almost as good as at Withington Infirmary in Manchester (1:10), where the nursing was described in a report in the *British Medical Journal* as of the same standard as in general hospitals, but poor by comparison with the General Hospital, Birmingham (1.4 in 1898).[168] However, a few years later, the training scheme was discontinued, but Birmingham infirmary continued to take pupils from the Workhouse Nursing Association, receiving a solitary fee of £20 for each trainee.[169] The General Hospital

[163] BCL, IMC, GP/B/2/4/4/1, 20 June 1889; GP/B/2/4/4/2, 26 January 1894.
[164] TNA, MH12/13365, 26 February 1892.
[165] Abel-Smith, pp.23-24.
[166] BPP, 1896 (371), p.28; Wildman, p.23.
[167] BPP, 1896 (371), pp.26-29.
[168] Anonymous, 'On Nursing in Workhouse Infirmaries', *British Medical Journal*, ii (1896), pp.857-59; C. J. Maggs, *The Origins of General Nursing*, London, 1983, p.90.
[169] BCL, Infirmary House Sub Committee (hereafter IHSC), GP/B/2/4/5/1, 23 October 1899.

had also discontinued its intake of paying probationers two years previously.[170] In 1902, Birmingham was training 88 probationers, with 27 in their first year, 32 in their second and 29 in their third and final year.[171] After the Central Midwives Board (hereafter CMB) was established that year, lectures by a medical authority were introduced to allow nurses to qualify for its diploma and training was extended to four years to allow for the additional number of deliveries required by the board to be carried out.[172]

Nurse training could not commence in Wolverhampton workhouse before a Superintendent Nurse had been appointed and the guardians did not decide to do so until 1893, when they advertised for a 'thoroughly competent' woman as 'Head Nurse' to be responsible for nursing throughout the workhouse and to 're-model' the nursing arrangements. From 14 applicants, they selected Miss Anna Menon, remunerating her annually with £35.[173] At the time of her application, she was a staff nurse at Walsall Cottage Hospital, but had received her training at Whitechapel Infirmary, London.[174] When the LGB approved the appointment of probationer nurses early the following year, it added the rider that the nurse staffing should be re-evaluated to ensure it was 'put upon an efficient footing'.[175] From the 105 applications, the board interviewed 10 candidates and appointed 4 probationers to serve two-year appointments at a salary of £10 annually. An additional two were appointed five months later, but only because of pressure exerted on the guardians by

[170] Wildman, 'Nursing at the General Hospital', p.23.
[171] BPP, 1902 [Cd. 1367], p.158.
[172] BCL, IHSC, GP/B/2/4/5/4, 26 March 1906.
[173] WALS, WBG, PU/WOL/A/24, 9 June and 21 July 1893; Workhouse Visiting Committee (hereafter WVC), PU/WOL/H/1, 19 May, 9 June 1893.
[174] WALS, *WC,* 26 July 1893.
[175] WALS, WBG, PU/WOL/A/24, 2 February 1894.

the LGB to improve staffing levels.[176] The board voted against Miss Menon being allowed to be present during the interviews, a factor which may have played a part in the large number of probationers leaving before completing their training.[177] However, this was not peculiar to Wolverhampton; for instance, 30% of probationers left before competing their training in Kensington Infirmary between 1890 and 1915.[178] The difficulty the guardians experienced in making appointments was that there were no criteria of suitability to assist them. The Departmental Committee into the Nursing of the Sick Poor in Workhouses in 1902 faced a similar problem and could only recommend that potential probationers should be of a minimum age of 21 years, of good character and health and have intelligence.[179] From the initial appointment of probationers to the opening of the new workhouse 10 years later, 12 resigned, although reasons were only given on two occasions. Nurse O'Reilly was accused of 'neglect of duty', while Gertrude Hill suffered an accident during a gale.[180] In addition, two probationers were deemed not fit to carry out their duties because of their state of health and one was assessed as unsuitable for nurse training by the MO. Early the next century, the MO in Birmingham workhouse reported that Dora Copeland had a cardiac murmur and 'must give up nursing'.[181]

The training complement of probationers in Wolverhampton workhouse had been increased to 12 by 1896 and the length of training increased to three years.[182] Two years later, three additional probationers were accepted from the Trained Nurses

[176] Ibid., 16 February, 6 July 1894; *WC*, 20 June 1893.
[177] Ibid.
[178] Lorentzen, p.9.
[179] BPP, 1902 [Cd. 1366], p.9.
[180] WALS, WBG, PU/WOL/A/25, 9 October 1896; WVC, PU/WOL/H/2, 1 October 1897.
[181] BCL, IHSC, GP/B/2/4/5/3, 9 February 1903.
[182] WALS, WVC, PU/WOL/11/2, 24 March, 24 July 1896.

Institution, each with a payment of £10.[183] In the same year, the Superintendent Nurse resigned and her appointed successor did likewise before taking up her appointment. She was replaced by Miss Maud Carter, in her late 20s, at an annual salary of £40.[184] There was also difficulty in appointing trained nurses at this time, with no applications for the post of charge nurse and so one of the probationers was upgraded.[185] This was not unique to Wolverhampton, as about a quarter of poor law medical institutions reported difficulty in recruitment around this time.[186] At the end of the century, the nurses not in training had been increased to 10 for day duty and 5 for night duty to care for 226 physically ill patients (nurse to patient ratio of 1:15, one of the lowest in Staffordshire).[187] In 1902, the House Committee debated the advisability of probationers being involved in the venereal wards, although they were under the supervision of charge nurses. They concluded that attendance on these wards was a necessary part of their training to become a 'fully informed nurse'. However, at the board meeting, Rev. Johnson had an amendment accepted that they should not do so within three months of their appointment.[188]

For adequate staffing at the infirmary of the new workhouse (opened in 1903), it was agreed that 6 charge nurses and 18 probationers would be required, an increase of 3 and 4 respectively.[189] Within four years, an additional 2 charge nurses and 9 probationers were needed.[190] In 1904, the LGB approved Wolverhampton infirmary as a training school for nurses and, six years later, the CMB recognised it as suitable

[183] Ibid., 28 January, 11 February 1898.
[184] WALS, WBG, PU/WOL/A/27, 13, 20 May, 3 June 1898.
[185] Ibid., 3 June 1898.
[186] BPP, 1902 [Cd. 1366], p.155.
[187] Ibid., PU/WOL/A/28, 8 June 1900.
[188] WALS, HC, PU/WOL/E/1, 31 December 1902; WBG, PU/WOL/A/30, 2 January 1903.
[189] WALS, General Purposes Committee (hereafter GPC), PU/WOL/E/1, 2 December 1903.
[190] WALS, HC, PU/WOL/E/2, 12 November 1907.

for training in midwifery, allowing it to be included in the trainees' programme.[191] Because of the guardians' concern that two probationers had resigned within three months due to physical incapacity to perform their duties, they required that all applicants pass a medical examination before appointment, carried out by the MO.[192] Another issue hindering training was the conscientiousness of the trainees. In 1903, the superintendent nurse, Miss Carter, complained of 'carelessness and neglect' by several probationers, who were exhorted by the guardians to make more effort in the best interest of the patients.[193] Two years later, the situation was reversed and after a two-hour meeting with the guardians, Miss Carter and probationers, she agreed to carry out her duties to the satisfaction of the guardians and the benefit of the nursing staff.[194] The second complaint against probationers for not taking an interest in lectures or studying as they ought was made by the resident MO. Once again, a meeting with the interested parties resolved the situation.[195] One probationer in particular, Annie Coyle, had neglected her studies, in addition to returning to duty late, making tea when on duty and leaving the ward unattended. She had previously been shown leniency, but was now dismissed.[196] Dismissals of probationers had been rare since transfer to the new workhouse, with only one other nurse so disciplined. The next year, Miss Carter resigned and was succeeded by Miss Annie Tyers, who had been night superintendent.[197] Certificates of completion of training included an assessment of probationers' proficiency, for example, in 1908 Nurses Wain and Prescott were both rated as 'good' for surgical nursing, medical nursing and

[191] WALS, WBG, PU/WOL/A/31, 29 July 1904; PU/WOL/A/34, 1 April 1910.
[192] Ibid., PU/WOL/A/31, 28 July 1905; HC, PU/WOL/E/2, 9 March 1905.
[193] WALS, HC, PU/WOL/E/1, 4 June 1903.
[194] Ibid., 23 February 1905.
[195] WALS, Special Committee, PU/WOL/P/1, 30 November 1906.
[196] Ibid.
[197] WALS, HC, PU/WOL/E/2, 25 July 1907.

obstetrical nursing. Prescott was given 'good' for conduct, but Wain was rated very good.[198]

The Conduct of Nurses and Patients

Was the reputation of workhouse nurses for inefficiency, negligence and being under the influence of alcohol while on duty justified? There were a few instances of nurses returning to the workhouse from leave in a drunken state, as in the 1850s in Birmingham, and this usually led to their resignation. The WMO complained on a number of occasions of nurses not carrying out his orders or exhibiting rudeness. Prior to the transfer to the new workhouse, the only report of drunkenness was that of George Bates, the nurse of the men's fever ward in 1843, but his dismissal may have resulted more from his use of 'violent language to the master'.[199] Subsequently, only one nurse was dismissed after returning 'drunk from leave' in 1882. Surprisingly, four months after Nurse Jane Thompson's dismissal, Nurse Cherton was merely reprimanded for the same offence.[200] The only other incident involving alcohol consumption was Nurse Rogers' contention that the superintendent nurse, Kate Nicholson, was 'tight' on the night that Nurse Harrison died in 1885. The guardians found the accusation was 'without foundation', and Nurse Rogers resigned.[201] The only incident in Wolverhampton workhouse in the nineteenth century of a nurse being reprimanded because of 'a state of intoxication' was in 1873 and involved the male

[198] Ibid., PU/WOL/E/2, 5 March 1908.
[199] BCL, HC, GP/B/2/3/1/1, 13 June 1843.
[200] BCL, HSC, GP/B/2/3/3/8, 4 July 1882; ISC, GP/B/2/4/1/1, 10 November 1882.
[201] BCL, ISC, 2/4/1/2, 4 September 1855.

nurse, Edwin Ladbrook, on his return to the workhouse one evening.[202] The only dismissals took place in the early decades of the twentieth century. Richard Newell, the attendant in the male mental wards, also returned from leave intoxicated at 11 o'clock in the morning and was still in the same state at half past seven in the evening.[203] Wheeley, the attendant on the male skin ward, did not pay his usual visit to the wards at eleven o'clock in the evening because of the 'influence of drink'.[204] It is impossible to know if alcohol was a factor in the many resignations by nurses, but the findings in Birmingham and Wolverhampton would support Anne Borsay's and Billie Hunter's assertion that tales of drunken and disorderly nurses are exaggerated.[205]

However, nurses were also dismissed for taking unapproved leave and returning late from leave without the consumption of alcohol being involved. After being in office only three weeks, male nurse William Stokes stayed away from Wolverhampton workhouse for two days in September 1868 and offered his resignation when asked for an explanation.[206] His replacement, Francis Eveson, repeated the offence by taking one day's leave within three months and he also resigned.[207] Thomas Lamb, underkeeper of the men's insane ward, and Ann Sholton, nurse of the lying-in ward, in the infirmary in Birmingham were more fortunate. Although they stayed out of the workhouse overnight in January 1844, they were merely reprimanded after expressing their contrition.[208] Leaving work without permission and patients unattended was one

[202] WALS, WBG, PU/WOL/A/15, 13 June 1873.
[203] Ibid., PU/WOL/A/33, 3 January 1908.
[204] WALS, HC, PU/WOL/E/4, 4 January 1912.
[205] A. Borsay and B. Hunter (eds), *Nursing and Midwifery in Britain since 1700*, Basingstoke, 2012, p.21.
[206] WALS, WBG, PU/WOL/A/13, 25 September 1868.
[207] Ibid., 19 January 1869.
[208] BCL, HC, GP/B/2/3/1/1, 16 January 1844.

of the most severe problems in voluntary hospitals, but Helmstadter and Godden consider that such behaviour was characteristic of the early nineteenth-century workforce in general.[209] Nursing staff were also charged with the more serious offence of assaulting patients. In 1854, Mrs Sarah Pugh, attendant in the female epileptic wards in Birmingham workhouse, resigned after she had severely beaten Caroline Morris in a dispute about the amount of money Morris had given to her for safe-keeping.[210] Pauper under-nurse Woolley was removed from her position in the epileptic wards in 1877 after using 'undue violence', resulting in an inmate's arm being broken.[211] The following year, Nurses Ankers and Harris were found guilty of gross cruelty for tying an aged inmate to her bed because of her inclination to wander about the ward.[212] Ten years later, Thomas Armitage, superintendent over the aged men, pushed Edward Heap over and dislocated his hip.[213] There were no further reports of assault in Birmingham after the separate infirmary opened the following year. In Wolverhampton workhouse in 1843, an inmate, Hannah Deakin, complained that Nurse Careless had beaten one of her children. When evidence of violence was found to be visible on the child, the nurse was reprimanded and removed from the nursery.[214] However, John Moore, a pauper attendant in the insane wards, who assaulted Thomas McDonald, was taken before the magistrates, suggesting male inmates were treated more severely than officers and female inmates in incidences of assault.[215] When, in 1876, an inmate in the lunatic wards, John Grainger, was found to have bruises, the guardians were satisfied that they had resulted from necessary force exerted in compelling him to take food and medicines. However, they did find

[209] Helmstadter and Godden, pp.12, 18, 39.
[210] BCL, VGPC, GP/B/2/2/1/1, 12 May 1854.
[211] BCL, HSC, GP/B/2/3/3/6, 13 November 1877.
[212] Ibid., 30 April 1878.
[213] BCL, WMC, GP/B/2/3/2/1, 15 June 1888.
[214] WALS, MJ, PU/WOL/U/2, 9 September 1843.
[215] WALS, WBG, PU/WOL/A/16, 14 May 1875.

the ward attendant guilty of beating Grainger with a pillow and removed the attendant from the ward.[216] Miss Steward, one of the assistants on the female insane ward, was reported in 1899 by the superintendent to have treated a patient roughly. The wardswoman, Elizabeth Thomas, said she had seen Steward strike a patient several times and place a pillow on her face. Steward denied this, but admitted she had had difficulty pacifying the patient. No action was taken, as Thomas' account could not be corroborated.[217]

Many of the instances of possible assault took place on the insane wards, where patients' behaviour could be very difficult to control at times, but staff members were also at risk of injury. For instance, in 1862, Charles Smith was admitted to the epileptic ward in Birmingham workhouse, with an attendant to keep a close watch on him. However, at five o'clock in the morning, he knocked the man over, kicked down a door, picked up a table and attempted to strike the attendant with it.[218] In Wolverhampton workhouse in 1907, there was an unprovoked assault by a patient on three nurses, two of which sustained serious injuries. The patient was charged with unlawful wounding and intent to do grievous bodily harm. Nurses Blackmore and Walker were allowed an additional two weeks leave after they had made a satisfactory recovery.[219] The few reported incidents of maltreatment of sick inmates by nurses suggest that general callousness towards patients was not prevalent in the workhouses of Wolverhampton and Birmingham.

[216] Ibid., 9 June 1876.
[217] WALS, WVC, PU/WOL/H/2, 1 December 1899.
[218] BCL, VGPC, GP/B/2/8/1/4, 1 August 1862.
[219] WALS, WBG, PU/WOL/A/33, 20 December 1907.

Summary

Standards of nursing care in workhouses depended on a number of factors. The number of nurses employed was less important than the ratio of nurses to sick inmates. In this respect, there was a significant deterioration in Wolverhampton workhouse as the century progressed. Although the guardians appointed additional staff to the insane wards, the number of nurses to care for the 80% increase in patients with physical illness remained at two. Birmingham guardians provided a higher standard of care, with a ratio of nurses to patients as good as the leading local voluntary hospital. Although, paradoxically, they reduced the number of nurses when moving to the new workhouse with a greater number of beds in the infirmary, they almost immediately appointed additional nurses and continued to do so as the number of sick inmates increased. What has become clear from the situation in Birmingham is that there was often little distinction between paid and pauper nurses, other than a salary differential (Table 6.6), and pauper nurses could move into the higher paid bracket, particularly after the guardians were prevented from paying them in cash. Some of the nurses appointed in 1849 had children resident in Birmingham's poor law institution for children and paid towards their keep from their wages. It is likely that they, themselves, would have been inmates if not employed as nurses. Abel-Smith quotes Louisa Twining's comment in 1885 that she had visited most London workhouses and the majority had no paid nurses.[220] However, the investigation by Birmingham guardians in 1856 showed that five large workhouses in London paid their nurses, as did six in the provinces.

[220] L. Twining, quoted in Abel-Smith, p.10.

The accepted generalisation that nurse turnover was high is borne out in both Wolverhampton and Birmingham, although more so in the former. However, with a greater number of nurses employed in Birmingham infirmary, the workhouse records did not detail routine replacement of nurses. In addition, the larger complement would have less impact on continuity, when compared with Wolverhampton. The introduction of nurse training in workhouses did not resolve the problem of high turnover, as many left before completing their training. Guardians accepted probationers readily after pauper nursing was prohibited, for they were less costly than trained nurses. Initially, they may have been regarded as a form of cheap labour as formal theoretical learning was not introduced until early in the twentieth century. As Sue Hawkins has emphasised, nurse training in the nineteenth century had as much to do with building character and instilling discipline, as with acquiring nursing skills.[221] However, Birmingham workhouse did subject its early probationers to an examination in 1883. According to Christopher Maggs, there was a qualitative change in attitude to those caring for the sick from 1881.[222] It was accompanied by a demand by nurses for greater professional recognition, the markers of which were the development of specific body knowledge and the beginning of the campaign for nurse registration.[223] On a local level, this was identified by the provision of a uniform. Nursing gained the status of a suitable occupation for single, middle-class women. However, it had become closely associated with the qualities of caring that were considered to be the hallmark of femininity.[224] Nursing reform had not accommodated male participation in general nursing and male nurses were deemed

[221] Hawkins, p.77.
[222] Maggs, 'Nurse Recruitment', p.23.
[223] C. E. Hallett, 'Nursing, 1830-1920: Forging a Profession', in A. Borsay and B. Hunter (eds), *Nursing and Midwifery in Britain since 1700*, Basingstoke, 2102, pp.59, 62.
[224] E. Gamarnikow, 'Nurse or Woman: Gender and Professionalism in Reformed Nursing 1860-1923', in P. Holden and J. Littlewood (eds), *Anthropology and Nursing*, London, 1991, p.110.

suitable only for mental health nursing.[225] For instance, no training school in London in the late nineteenth century would accept men.[226] Probationers appointed in Birmingham and Wolverhampton were exclusively female and from that time men were retained only on the male lunatic wards. Historically, male nurses have been relatively neglected by researchers as a source of study, possibly because they have been regarded as a 'social anomaly'.[227] In the workhouses of Birmingham and Wolverhampton, they had a prominent place in the nursing complement and participated in general nursing prior to the introduction of training. Thereafter, their numbers dwindled, so that there was only one male nurse among a nursing staff of 33 in Birmingham workhouse in 1883.[228] Consequently, their contribution to general nursing prior to the reforms has not been given due recognition.[229]

There is no doubt that nurse training improved the standard of nursing in the late nineteenth and early twentieth century, but it is more difficult to judge if it influenced the caring nature of nurses. The MO in Wolverhampton in 1860 was in no doubt that poor law nurses showed no sympathy toward their patients. On the other hand, two patients in Birmingham expressed their gratitude at the 'extreme kindness' and 'every care and kindness' shown during their stay in the institution.[230] Furthermore, instances of maltreatment of patients and nurses were rare in both institutions. Murray Browne, a LGB inspector, was very complimentary about the quality of nursing in Birmingham infirmary in 1893, stating that 'he could not see how rich

[225] E. Gamarnikow, 'Sexual division of labour; the case for nursing', in A. Kuhn and A. Wolpe (eds), *Feminism and Materialism*, London, 1978, p.114; Mackintosh, p.233.
[226] C. Hart, *Nurses and Politics: the Impact of Power and Practice*, Basingstoke, 2004, p.102.
[227] R. Dingwall, 'The place of men in nursing', in M. M. Colledge and D. Jones (eds), *Readings in Nursing*, Edinburgh, 1979, pp.199, 202.
[228] BCL, BBG, GP/B/2/1/51, 12 December 1883.
[229] Hart, p.101.
[230] BCL, VGPC, GP/B/2/8/1/9, 26 September 1884; Workhouse Infirmary Management Committee, GP/B/2/4/4/4, 15 December 1902.

people in sickness would be any better off'.[231] However, those patients who remained in the workhouse did not fare as well. In conclusion, the standard of nursing care varied at different times and in different parts of the workhouses, although the general trend was one of improvement, but not always a steadily progressive one. Important events in this narrative were the appointment of paid nurses (in Wolverhampton in 1839); trained nursing superintendents (in Wolverhampton in 1893 and Birmingham workhouse in 1878) and a trained matron in Birmingham infirmary in 1889; the introduction of probationer nurses in place of inmates (in Wolverhampton in 1894 and Birmingham in 1883); and the guardians' agreement to increase nurse staffing to meet increasing workload at various times during the study period. The overall quality of care provided under the NPL, which did not depend solely on nursing care, will be addressed in the next and final chapter.

[231] BCL, BBG, GP/B/2/1/61, 1 February 1893.

CONCLUSION

This detailed microstudy examining and comparing the medical provision and care in two west midlands workhouses has contributed to the debate over the standard of medical care provided by the poor laws. In assessing the standard of medical care, it has demonstrated that Birmingham and Wolverhampton guardians took markedly different approaches to the provision for sick paupers. However, the assessment of standards of care is complicated and Guenter Risse reminds us that care is a 'complex transaction involving a variety of individuals in distinctive sick and caring roles' and that healing services can provide a number of distinct functions.[1] Thus, several of these aspects in relation to the range of institutional medical services provided by the guardians in the two towns will be considered, in response to the questions raised at the beginning of each chapter.

One of the important medical roles of the workhouse was the care and treatment of paupers suffering from chronic illness and disability, as they had access to few other avenues of institutional care. They were rarely identified as a distinct group of inmates, and Wolverhampton workhouse was typical in this respect. The opportunity to discern their nature and care needs arose in Birmingham due to its designation of some wards as 'the bedridden wards'. Disabled inmates were found to form a sizeable proportion of workhouse inmates, have a range of disability levels and require considerable medical and nursing attention. The majority were in the older age group, resulting in the workhouse gaining the reputation as the institution of the aged by the late nineteenth century. The inclusion of disabled paupers among those in

[1] G. Risse, 'Medical Care', in W. F. Bynum and R. Porter (eds), *Companion Encyclopaedia of the History of Medicine*, Vol. 2, London, 1993, pp.45-46.

the care of the workhouse medical officer in the early years of the NPL demonstrates how disability became medicalised. However, later in the century, those requiring less in the way of direct medical care, for example, needing few or no drug prescriptions, were seen as requiring less medical care and thus acquired a lower status in medical eyes. For older and disabled inmates, the quality of care they received declined toward the end of the nineteenth century and did not alter until medical interest in the care of older people arose in the 1930s.[2] This comparative neglect of sick inmates with chronic medical conditions developed as acute medical treatment became more predominant within the institution. However, Birmingham and Wolverhampton workhouse infirmaries played an important part in the provision of medical care for paupers with short-term acute illnesses from early in the study period. For instance, almost one-third of patients in these workhouses had acute medical and surgical conditions in 1869, similar proportions to the average for Warwickshire and Staffordshire, but greater than the four-fifths in Middlesex and Surrey, which included inner London workhouses.[3]

A significant element of that acute care was provided for patients with infectious and epidemic diseases. These patients, like those with chronic disability were usually 'unwanted' by non-poor law institutions. Indeed, for patients in Birmingham and Wolverhampton with a wide range of communicable disease, there was little alternative to admission to the workhouse infirmaries. In the earlier part of the century, they were either excluded from admission to voluntary hospitals or could not

[2] For the development of the specialty of geriatric medicine, see M. J. Denham, 'The History of Geriatric Medicine and Hospital Care of the Elderly in England Between 1929 and the 1970s', (unpublished PhD thesis, University of London, 2004); A. Ritch, 'History of Geriatric Medicine: from Hippocrates to Marjory Warren', *Journal of the Royal College of Physicians of Edinburgh*, 42 (2012), pp.368-74.
[3] British Parliamentary Papers, 1870 (468-I), pp.12-14, 19-21, 29.

be accepted because of the small number of beds available. Later in the century, sanitary authorities were slow to erect isolation facilities, even after isolation hospitals were considered to be one of the 'major weapons' in containing the spread of infection and the Public Health Act (1875) allowed compulsory isolation of infectious patients.[4] This is surprising since, as Paul Weindling points out, combating epidemics and endemic infectious disease was a major concern of nineteenth-century medicine.[5] However, the need for isolation was met by workhouse facilities and was one area where the principle of less-eligibility did not apply. When epidemics struck, it was boards of guardians who had to respond by erecting temporary facilities, such as sheds or tents in the workhouse grounds or by vacating wards and transferring inmates to other workhouse accommodation in defiance of the classification system. They also had to employ additional medical and nursing staff. As demonstrated by events in Wolverhampton, this pressure resulted in co-operation between guardians and the local sanitary authorities on some occasions and conflict on others. Isolation assisted in the prevention of the spread of disease and, in this regard, guardians were providing a beneficial service to the local community that went beyond the requirements of the poor law system. An outstanding example of this was in Birmingham, where co-operation between the poor law and sanitary authorities resulted in the joint management of facilities for infectious disease. This study has demonstrated that poor law medical facilities were an essential component of the management and treatment of communicable diseases in the nineteenth and early twentieth centuries. Unfortunately, the records do not reveal the medical therapy that patients with fevers received.

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[4] J. V. Pickstone, *Medicine and Industrial Society: a history of hospital development in Manchester and its regions 1752-1946*, Manchester, 1985, p.178.
[5] P. Weindling, 'From infectious to chronic diseases: changing patterns of sickness in the nineteenth and twentieth centuries', in A. Weir (ed.), *Medicine in Society*, Cambridge, 1992, p.304.

Throughout the nineteenth century, there were few drugs available to medical practitioners that would provide a cure, other than sulphur for scabies, and in the early twentieth century, salvarsan for syphilis. Alcohol in one form or another was the most popular remedy for many acute illnesses and its cost was a substantial proportion of the guardians' budgets in Birmingham and Wolverhampton. The increase in the amount consumed in Wolverhampton workhouse in the 1840s was attributed by the medical officer to the opening of fever wards, suggesting that it was being prescribed for infectious diseases. The evidence from the expenditure on alcohol in both workhouses suggests that it was given in the same manner and to the same extent as in voluntary and isolation hospitals. With regard to tuberculosis, guardians did more than merely provide accommodation for isolation, although this role was still important as they provided more beds than the local authority as late as the 1920s.[6] The workhouse medical officers in both Birmingham and Wolverhampton instituted similar methods of medical management to those in use in sanatoriums. Moreover, despite the constraints imposed upon them, medical officers kept control of pharmaceutical treatments and medical extras, even when guardians were paying the drugs bill. Chapter 5 questioned whether Birmingham and Wolverhampton guardians were able to limit the treatments that inmates could receive and over-rule medical officers' prescriptions and advice. The incontrovertible answer is that they were not. The change in Wolverhampton in the 1870s, when the medical officer no longer had to meet the cost of drugs out of his salary, appeared to have no effect on prescribing, confounding the general assumption that medical extras were ordered in preference to drugs to protect the medical officers' salaries. At times, workhouse medical officers introduced new treatments, both medical and surgical,

[6] Pickstone, p.213.

and new forms of care within the workhouse, such as open-air therapy for tuberculosis. Patients appeared satisfied if they received from the medical officer the type of treatment they expected and within a reasonable time. The one area that guardians managed to restrict was surgery within the workhouse, but their preference was to transfer patients to a local voluntary hospital, where they paid an annual subscription or were prepared to pay on an individual basis. The restriction gradually lessened toward the end of the nineteenth century as the number of medical officers increased and facilities improved with the provision of an operating room. Furthermore, anaesthetic agents were used for operations on inmates soon after they became available, with the guardians paying an additional doctor for administering them.

Some of the medical officers employed in both towns strove to provide as high a standard of medical care as was possible and at times succeeded despite their heavy workload. On the other hand, others were content to carry out their duties in a manner that satisfied the guardians and were content to accept increases in salary as patient numbers increased, rather than request additional professional assistance. Birmingham's example indicates that sufficient medical staffing was provided at times, in the early period after the NPL as a legacy of the previous system, and later when the infirmary was aligned with voluntary hospitals. The workhouse infirmary attracted medical officers of high quality at times throughout the century and visiting physicians and a surgeon who also had honorary appointments at the local voluntary hospitals. At least one of the physicians tailored his treatment of sick inmates to match that offered to patients in hospital. Birmingham's medical culture, that included the establishment of medical training and education, was, no doubt important

in attracting medical men of standing to take up poor law posts. The establishment in Birmingham of an infirmary under the management of officers distinct from the workhouse was an impetus to improve the level and quality of medical staffing. Nothing similar occurred in Wolverhampton, where the workhouse and infirmary remained integrated. Throughout the nineteenth century, the single, part-time medical officer in a town such as Wolverhampton could hardly be expected to provide more than basic attention because of the excessive workload.

Although the study did not set out to consider conflict with the guardians and charges of negligence as major components, they have been dealt with in detail as they arose directly from the working conditions of the medical officers and had a bearing on standards of care. As John Stewart and Steve King point out, a 'war of attrition' between guardians and medical officers would hardly be conducive to effective patient care.[7] In addition, Kim Price considers the frequency of occurrence of charges of negligence to be some measure of the quality of medical practice.[8] Nevertheless, many of the instances recorded in this study were not brought about by the practice of poor standards of patient treatment, although complaints by patients could be the stimulus for investigation. More often, it was the guardians' need to exert control over medical relief that led to strained relationships. Despite this, many poor law patients in the nineteenth century benefited from the administrations of their medical attendants, the extent depending on how conscientious and caring an individual doctor was rather than his relationship with the guardians. This conclusion is in agreement

[7] J. Stewart and S. King, 'Death in Llantrisant: Henry Williams and the New Poor Law in Wales', *Rural History*, 15 (2004), p.81.
[8] K. Price, 'The Shape of the Iceberg', in J. Reinarz and R. Wynter (eds), *Complaints, Controversies and Grievances in Medicine*, London, 2014, pp.129-46.

with Price's claim that the quality of care in workhouse infirmaries can be judged almost entirely by the standards of their medical officers.[9]

That is not to say that nursing care was unimportant, but it was less patient-centred in the early years of the NPL, when even paid nurses carried out more household tasks than they gave personal attention to patients. Wolverhampton workhouse relied heavily on pauper nursing throughout the nineteenth century and the guardians were reluctant to take any steps that would require the employment of more paid staff. Although Birmingham employed a greater proportion of remunerated nurses, the differentiation between them and pauper nurses was indistinct in the early years of the NPL, as inmates were taken on as paid nurses. This study confirms the high turnover of nursing staff previously reported, but could not identify a major cause for the frequent resignations. However, the heavy workload and harsh conditions may have led to many nurses resigning without wishing to disclose their reasons. Once training was introduced and it became more formalised toward the end of the century, standards of nursing care improved in terms of attitude to patient management, rather than the acquisition of specific nursing skills. One disadvantage of the nursing reforms was to drive men away from general nursing in workhouses and diminish their role within the developing nursing profession. General nursing standards were less than acceptable in workhouses such as Wolverhampton that relied on pauper assistance to supplement a few paid nurses. Whereas, even in the early days of the NPL, standards in Birmingham workhouse appeared to be similar to those in the voluntary hospitals and nursing staff moved between the two types of institution.

[9] K. P. Price, 'A regional, quantitative and qualitative study of the employment, disciplining and discharging of workhouse medical officers of the New Poor Law throughout nineteenth-century England and Wales', (unpublished PhD thesis, Oxford Brookes University), 2008, p.336.

One of the objectives of the study was to ascertain by what point in the nineteenth century that Birmingham and Wolverhampton workhouses had become significant medical spaces. There is a consensus that an extensive system of poor law health care had developed in provincial England by the end of the nineteenth century.[10] However, the point before then at which the workhouse became more medicalised and care improved is in dispute. Improvements occurred in the early 1870s as a result of the Metropolitan Poor Act, with better accommodation resulting from the erection of many new buildings and a higher standard of care in the new infirmaries separated geographically from the workhouse.[11] However, Price maintains that the crusade against outdoor relief extended the less-eligibility principal to medical care in the workhouse and put pressure on guardians to cut costs. The result was lower care standards, brought about in part by the reduction in medical staffing.[12] However, the crusade had no detrimental effect on the number of medical officers in either Birmingham or Wolverhampton, indeed they were increased in the mid-1870s in the former's workhouse. The impact of the crusade waned and poor law infirmaries were providing sufficiently high standards of care to attract non-pauper patients by the early 1890s. They had also narrowed the gap between themselves and voluntary hospitals by this time.[13] In this regard, Wolverhampton workhouse lagged behind the general picture, as standards did not improve substantially, including the appointment

[10] S. Fowler, *Workhouse: The People, The Places*, *The Life Behind Doors*, Richmond, 2007, p.164; A. Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911*, Cambridge, 1994, p.247; D. R. Green, 'Medical Relief and the New Poor Law in London', in O. P. Grell, A. Cunningham and R. Jütte (eds), *Health Care and Poor Relief in 18th and 19th Century Northern Europe*, Aldershot, 2002, p.240; A. Crowther, 'Health Care and Poor Relief in Provincial England', in O. P. Grell, A. Cunningham and R. Jütte (eds), *Health Care and Poor Relief in 18th and 19th Century Northern Europe*, Aldershot, 2002, p.207; S. King, 'Poverty, Medicine and the Workhouse in the Eighteenth and Nineteenth Centuries', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse*, Rochester, 2013, p.237.

[11] K. Morrison, *The Workhouse: A Study of Poor-Law Buildings in England*, Swindon, 1999, p.116; R. G. Hodgkinson, *The Origins of the National Health Service: the Medical Services of the New Poor Law 1834-71*, London, 1967, p.685; Fowler, p.164, Green, 'Medical Relief and the New Poor Law', p.240.

[12] Price, 'Regional, quantitative and qualitative study', pp.109-10, 339.

[13] Digby, p.247; Fowler, p.144.

of a resident medical officer, until the move to the new workhouse in the first decade of the twentieth century. This delay is surprising, as the guardians had accepted the responsibility of providing for sick paupers as early as the mid-1840s.

In contrast, medicalisation of the workhouse had taken place in Birmingham well before the NPL and standards of care did not diminish until the reductions in medical and nurse staffing in the 1850s. However, a gradual improvement commenced later that decade, reaching satisfactory levels 20 years later, so that by the 1890s, the infirmary was functioning similarly to a voluntary hospital. However, it is ironic that from that time, care deteriorated for patients who remained in the workhouse and remained so at least until the outbreak of war in 1914. The experience of Birmingham demonstrates that conditions could vary over time within a single institution and not necessarily for the better. Birmingham's variability contradicts the typical narrative of the poor law medical service as one of steady progress toward the establishment of the National Health Service. The comparison between Birmingham and Wolverhampton demonstrates how poor law medical provision could be very different in two industrial towns situated only 15 miles apart. This example emphasises that caution is needed in generalising with regard to standards of care and in interpreting regional comparisons.

This analysis of the quality of care delivered in the two workhouses in the west midlands contributes to the debate over whether it was better or worse under the NPL than before. Proponents of the OPL point to a well-established medical service by the eighteenth century, with the arrangement of medical treatment an essential part of

overseers' duties.[14] The quality of care was considered reasonable at worst and impressive at best and the authorities' approach to medical provision sympathetic and generous.[15] Michael Flinn takes the contrary view that, under the OPL, there was only a rudimentary medical service for the poor.[16] The positive viewpoint is based on the range of outdoor medical relief provided by parishes and a standard of care that was felt to be no different to that received by the general population.[17] It underestimates the role of the workhouse, which Anne Crowther suggests was hardly ever used as 'a centre for the sick'.[18] The unimportance of this function of the workhouse has been challenged by Kevin Siena with regard to London. He asserts that workhouses in the capital provided a significant level of institutional health care by the early eighteenth century.[19] He cites St Margaret's workhouse in London, which increased its provision of sick rooms substantially within two years of its erection in 1725.[20] He is supported in this view by Jeremy Boulton, Romola Davenport and Leonard Schwarz, who estimated that around 20% of inmates in St Martin's in the Fields workhouse were sick in 1817-18. However, London's response to the poor laws was different from that in the provinces, with its greater reliance on institutional care. Furthermore, the development of the majority of its workhouses occurred in the eighteenth rather than the nineteenth century.[21] The situation outside the metropolis remains uncertain, but the proportion of sick inmates (17%) in the

[14] J. Lane, *A Social History of Medicine*, London, 2001, p.54; K. P. Siena, *Venereal Disease, Hospitals and the Urban Poor: London's "Foul Wards", 1600-1800*, Rochester, 2004; E. G. Thomas, 'The Old Poor Law and Medicine', *Medical History*, 24 (1980), p.1.
[15] Digby, p.230; Thomas, p.3; I. Loudon, 'The Nature of Provincial Medical Practice in Eighteenth-century England', *Medical History*, 29 (1985), p.27.
[16] M. W. Flinn, 'Medical Services under the New Poor Law', in D. Fraser (ed.), *The New Poor Law in the Nineteenth Century*, London, 1976.
[17] Digby, p.230; Loudon, p.27.
[18] Crowther, p.209.
[19] Siena, *Venereal Disease*, pp.136, 178.
[20] K. Siena, 'Contagion, Exclusion and the Unique Medical World of the Eighteenth-Century Workhouse', in J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse*, Rochester, 2013.
[21] D. R. Green, 'Icons of the New System: Workhouse Construction and Relief Practices in London under the Old and New Poor Law' *The London Journal,* 34 (2009), pp.265-68.

urban workhouse in Birmingham in the third quarter of 1818 equates its medical role with that of London workhouses.[22] Thus Birmingham had a well-developed poor law institution, providing as good a quality of medical services as could be expected in the early the nineteenth century, with one resident and several visiting surgeons, plus paid nurses.

Historians who suggest that medical attention improved immediately after the NPL do so on the basis of studies of workhouse care, as there is no doubt that outdoor medical relief was restricted in the range and possibly the standard of care.[23] The crusade against outdoor relief in the early 1970s lowered standards of assistance for outdoor paupers further.[24] Irvine Loudon is not in agreement with this position, concluding that medical care under the NPL was inadequate due to low financial incentives for doctors, understaffing with surgeons and the stigma of pauperism, but his study is mainly concerned with outdoor relief.[25] However, it is in accord with the general opinion that standards of medical services deteriorated in the majority of unions in the early years after the NPL.[26] Thus, Birmingham guardians would have been exceptional in continuing to provide the same standard of care as under the OPL for more than a decade into the NPL. The decline did not occur in Birmingham until the PLB issued rules, orders and regulations for the government of the workhouse in January 1850, resulting in a reduction in the number of medical and nursing staff. In Wolverhampton, the low medical and nursing levels from the establishment of the

[22] Birmingham Central Library, Birmingham Board of Guardians, GP/B/2/1/2, 27 October 1818, 19 January, 1819; no information is available for Wolverhampton workhouse under the OPL.
[23] Hodgkinson, p.64; N. Longmate, *The Workhouse*, London, 1974; D. Fraser, 'The English Poor Laws and the Origins of the British Welfare State', in W. J. Mommsen (ed.), *The Emergence of the Welfare State in Britain and Germany, 1850-1950*, London, 1981, pp.14-18.
[24] Digby, p.244; Price, 'A regional, quantitative and qualitative study', p.339.
[25] I. Loudon, *Medical Care and the General Practitioner 1750-1850*, Oxford, 1986, p.244.
[26] Fowler, p.151; Digby, p.244; S. King, 'Poverty, Medicine and the Workhouse', p.237.

union suggest that care did not meet satisfactory standards until near the end of the century. Furthermore, the fact they remained unchanged throughout the nineteenth century in the face of increasing patient numbers meant there was a steady deterioration in the provision of care. The findings from this study again caution against generalisation and suggest that the variation in quality of care at different periods of time were not invariably influenced by national events or central authority diktat. Whether Birmingham and Wolverhampton were similar to other towns or exceptional requires further local studies.

This study has uncovered a few areas where the care in workhouse infirmaries appears to be similar to that in voluntary hospitals. For instance, some nurses in Birmingham moved between two types of institution, but how many did so and how frequently? The other similarity between care in the infirmary and hospital was the treatment of pneumonia by a visiting physician to both types of institution in Birmingham. Once again, this is an isolated example and whether it occurred in other cases can only be determined by additional studies. Furthermore, little has been uncovered regarding the treatment prescribed for infectious diseases and for patients admitted with acute conditions, other than nutritional supplementation. Medical therapy was rarely recorded in the separate infirmary in Birmingham, and it may be possible to uncover this detail by investigating similar poor law institutions. Copies of prescriptions uncovered were typical of the time in being impossible to decipher (see the case records of the patient in Appendix C) and would require a dedicated investigation. In addition to a paucity of detail on medical treatments, little is understood on how medical care affected the lives of sick inmates. However, figures for admissions and discharges in Birmingham and Wolverhampton suggest a

significant number of those receiving indoor medical relief were able to return to their communities in an improved condition, if not cured. The stories of applicants for outdoor medical relief, mostly under the OPL, have begun to be revealed by historians, but the voices of sick inmates after the NPL remain unheard. This study has produced a few of their experiences, mainly through complaints about treatment, and further microhistories are required to create a more complete narrative.[27] Future research should be directed toward comparing the overall standard of medical care in workhouse infirmaries with that practised within non-poor law medical institutions, as this study has challenged the view that indoor medical relief was consistently inferior until the late nineteenth century. Finally, local arrangements for the provision of institutional care and isolation as tools in the prevention of the spread of infection within a community and the poor law's role within them needs further exploration.

Furthermore, it does not accord with the traditional understanding of poor law medical care as a narrative of progressive improvement toward the establishment of the National Health Service in 1948. Instead, the story demonstrates the variability of medical care within the same workhouse over time and between two institutions in adjacent towns. The standard of care improved significantly by the beginning of the twentieth century, as occurred in Birmingham's voluntary hospitals over the same period.[28] In this sense, the workhouse infirmary had responded to advances in medical science and nursing education that had taken place throughout the nineteenth

[27] S. King, '"Stop this Overwhelming Torment of Destiny": Negotiating Financial Aid at Times of Sickness under the English Old Poor Law, 1800-1840', *Bulletin of the History of Medicine*, 79 (2005), pp.228-60; S. King, T. Nutt and A. Tomkins (eds), *Narratives of the Poor in Eighteenth-Century Britain*, Vol.1, London, 2006; S. King, 'Regional Patterns in the Experiences and Treatment of the Sick Poor, 1800-40: Rights, Obligations and Duties in the Rhetoric of Paupers', *Family and Community History*, 10 (2007), pp.61-75; A. Gestrich, E. Hurren and S. King (eds), *Poverty and Sickness in Modern Europe: Narratives of the Sick Poor* , London, 2012, pp.23-24.
[28] J. Reinarz, *Health Care in Birmingham*, Woodbridge, 2009, pp.240-47.

century. By demonstrating the complex nature of institutional medical care for the destitute, this study advances the new perspective of workhouse medicine that emerged in the essays published in *Medicine and the Workhouse*.[29] The workhouse infirmary emerges as the provider of an important element of medical care for the poor in its own right in the nineteenth and early twentieth centuries and not merely as a stepping-stone to later developments. Furthermore, despite the constraints of being stigmatised as paupers and subjected to authoritarian discipline, sick inmates experienced conditions that were better than those portrayed by the pessimistic interpretations of the older historiography of the NPL.

[29] J. Reinarz and L. Schwarz (eds), *Medicine and the Workhouse*, Rochester, 2013.

APPENDIX A

Prevalence of Selected Infectious Diseases in Birmingham Workhouse on the Last Day of the First Week of Each Quarter for the Years 1877-1880 and 1894-1911

Quarter and year	Whooping cough	Measles	Diphtheria	Typhoid	Itch
Lady Day 1878	16	3		1	
Midsummer 1878	33			2	
Michaelmas 1878	29				
Christmas 1878	17			2	26
Lady Day 1879	10			2	23
Midsummer 1879	8	40			18
Michaelmas 1879	13				27
Christmas 1879	4	3			
Lady Day 1880	5			1	56
Midsummer 1880		18			28
Michaelmas 1880	35	2			37
Christmas 1880	35			3	24
Midsummer 1894		9		1	4
Christmas 1894	1				4
Lady Day 1895					4
Midsummer 1895	2			3	1
Michaelmas 1895	16			2	3
Christmas 1895	7			5	
Lady Day 1896	3	6		6	1
Midsummer 1896	1			2	4
Michaelmas 1896	9			3	
Christmas 1896	4			1	1
Lady Day 1897	1	3		4	
Midsummer 1897	2		3	3	
Michaelmas 1897		4			1
Christmas 1897	2	1		2	1
Lady Day 1898	2			4	
Midsummer 1898	2	2		3	
Michaelmas 1898	3			2	
Christmas 1898	3				1
Lady Day 1899		20		4	1

Midsummer 1899	1	1			4
Michaelmas 1899	2				2
Christmas 1899	1	1			4
Lady Day 1900	3	3			6
Midsummer 1900	24				
Michaelmas 1900	17	2			6
Christmas 1900		1			1
Lady Day 1901					1
Midsummer 1901	1	11	1		2
Michaelmas 1901	5		2		3
Christmas 1901	4		3		4
Lady Day 1902	6	15	3		10
Midsummer 1902	10	5	2		6
Michaelmas 1902	10	2	1		13
Christmas 1902	9	2			14
Lady Day 1903		1	2		5
Midsummer 1903	7				6
Michaelmas 1903	1	9			7
Christmas 1903	1				6
Lady Day 1904			1		6
Midsummer 1904	5	20	2		9
Michaelmas 1904	16	1			3
Christmas 1904	8		7	1	6
Lady Day 1905	10	1	1		6
Midsummer 1905	4	3			10
Michaelmas 1905		5	1		7
Christmas 1905	5	8			9
Lady Day 1906	7				10
Midsummer 1906	3				12
Michaelmas 1906	1	1	2		5
Christmas 1906					14
Lady Day 1907	1	9			18
Midsummer 1907	1	1	1		14
Michaelmas 1907	5				8
Christmas 1907					8
Lady Day 1908	12		2		20
Midsummer 1908	17	2	1		13
Michaelmas 1908	7				8
Christmas 1908					13

Lady Day 1909	7	5	3		15
Midsummer 1909	5	18			10
Michaelmas 1909		1	2		9
Christmas 1909	2		2		12
Lady Day 1910	2				12
Midsummer 1910	35		1		12
Michaelmas 1910	25				27
Christmas 1910	19				15
Lady Day 1911	13	14			19

Source: Birmingham Central Library, Local Government Board Returns, GP/B/5/1/1-8, 1877-1911.

APPENDIX B

Medical Relief in Birmingham Workhouse for Selected Weeks, 1851-56[1]

Week ending	N^{o} on Medical Relief	All Infectious diseases	Cutaneous Diseases	Fever (mild)	Fever (typhus)	Diarrhoea	Consumption
25 October 1851	246	25	0	7	2	8	2
6 December 1851	124	16	1	4	2	4	3
3 January 1852	134	9	4	5	0	2	1
3 April 1852	139	16	1	2	3	3	6
3 July 1852	176	33	13	5	1	5	8
2 October 1852	172	33	12	5	11	5	0
25 December 1852	154	26	12	8	1	5	9
2 April 1853	202	42	14	4	0	7	13
9 July 1853	191	34	15	5	0	4	8
1 October 1853	166	32	7	3	1	6	5
7 January 1854	246	35	10	2	0	10	7
1 April 1854	249	44	20	4	1	0	9
1 July 1854	246	53	18	6	1	7	16
7 October 1854	226	42	12	2	1	10	11
16 December 1854	280	44	20	3	1	4	12
15 March 1856	385	65	28	7	0	0	9

Source: TNA, MH12/13297-99, 13300.

[1] Diarrhoea is included in the total number of infectious diseases as it appeared this way in the records: fever labelled as typhus would have included the infection later separately identified as typhoid.

APPENDIX C

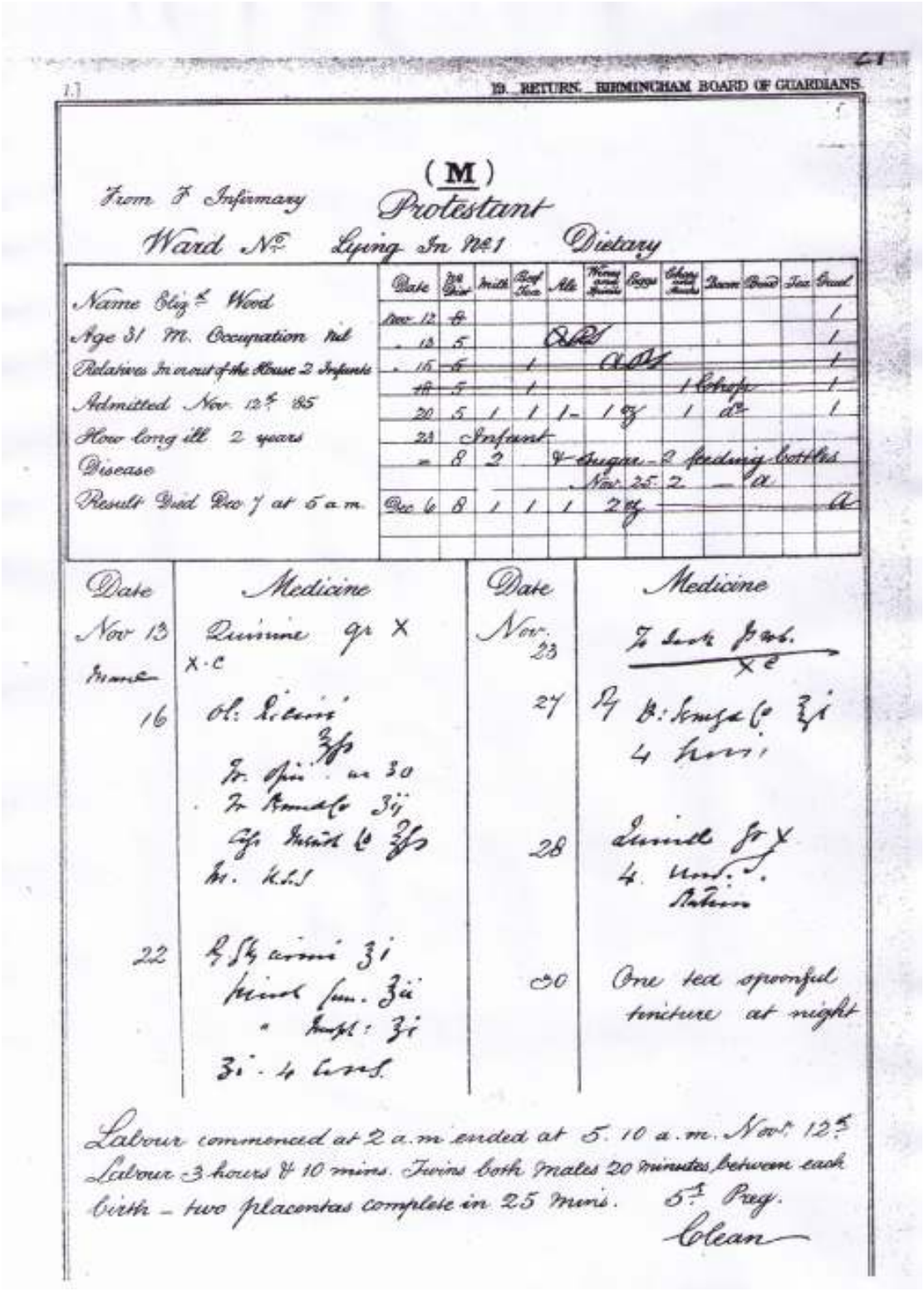
List of drugs kept in the wards of Birmingham Infirmary in 1896

Drug	Comment
Carbolic (1 in 20)	Lotion
Boracis	Astringent; used for diarrhoea
Plumbi	Astringent; used for constipation and in neurological conditions
Belladonna	For pain relief, as muscle relaxant, to reduce bronchial secretions
Saponis	Soap, for dyspepsia and purging
Terebenth Acetum	Turpentine, as diuretic and cathartic internally; in plasters externally
Lime Water	Tonic, astringent; used for bladder stones
Olive Oil	Laxative, expectorant
Castor Oil	Laxative
Brandy or Whisky	Stimulants
Mist Terrae Co	Mixture
Mist Stimulant	Mixture of iron, strychnine, phosphoric acid
Mist Ammon et Senegae	Mixture;used for coughing and to promote sweating
Pil Cal cum Col	Pill, containing colocynth and calomel; purgative
Pulv Calomelanos	Powder, of mercurous chloride; purgative
Ung Zinci	Ointment for eyes and ulcers
Ung Boracis	Ointment containing borax
Silv Amyli et Zinci Oxide	Contains zinc; tonic, antispasmodic
Pig Iodi	Possibly ointment; contains iodine; used for ringworm
Mist Alba	Mixture, possibly containing soap, ammonia, turpentine or magnesium; cathartic

Sources: BCL, WIMC, GP/B/2/4/4/2, 15 May 1896; comments collated from W. Buchan, *Domestic Medicine*, 6th edition, London, 1799; T. J. Graham, *Modern Domestic Medicine*, 10th edition, London, 1848; *The British Pharmacopoeia 1932*, London, 1932; A. O. Bentley, *A Text-book of Pharmaceutics*, London, 1933; G. B. Risse, *Hospital Life in Enlightenment Scotland: Care and Teaching at the Royal Infirmary of Edinburgh*, Cambridge, 1986.

APPENDIX D

Elizabeth Wood's Clinical Chart, Birmingham Infirmary, 1885



19. RETURN. BIRMINGHAM BOARD OF GUARDIANS.

(M)

From B Infirmary Protestant

Ward No Lying In No 1 Dietary

Name Eliz^a Wood
Age 31 M. Occupation Nil
Relatives in or out of the House 2 Infants
Admitted Nov 12^th 85
How long ill 2 years
Disease
Result Died Dec 7 at 6 a.m.

Date	Mil Diet	Milk	Beef Tea	Ale	Wine and Spirits	Eggs	Chicken and Broth	Bacon	Bread	Tea	Gruel
Nov 12	6										1
" 13	5										1
" 15	6		1								1
" 18	5		1				1 Chop				1
" 20	5	1	1	1-	1 oz		1	do			1
" 23	Infant										
" 25	8	2			Sugar - 2 feeding bottles						
Nov 25						2		a			
Dec 6	8	1	1	1	2 oz						a

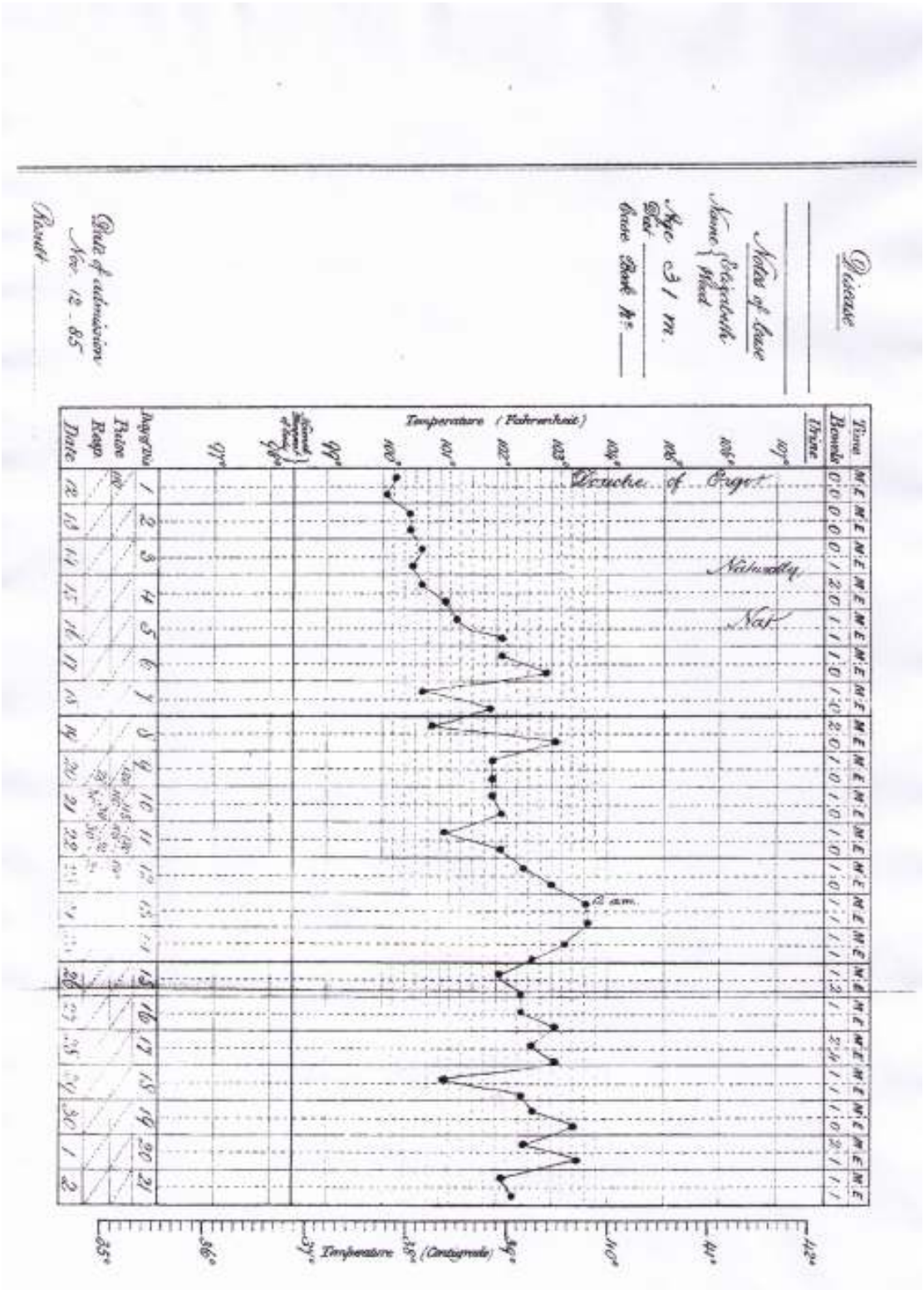
Date	Medicine
Nov 13	Quinine gr X
	X-C
16	Ol: Ricini ℥ss
	Tr. Opii ℥ 30
	Tr Rhei Co ℥ij
	Aq. Menth Co ℥ss
	M. ft. Mist
22	R Sp amm ℥i
	Mist Camph. ℥ii
	" Aq: ℥i
	℥i. 4 hors

Date	Medicine
Nov. 23	To take pro.
	X 2
27	R Ol: Ricini Co ℥i
	4 hours
28	Linimt Sp X
	4. Omn. h.
	Return
30	One tea spoonful tincture at night

Labour commenced at 2 a.m ended at 5. 10 a.m. Nov^r 12^th
Labour 3 hours & 10 mins. Twins both males 20 minutes between each birth - two placentas complete in 25 mins. 5^th Preg.
Clean

Source: British Parliamentary Paper, 1886, (19-Sess. 2), p.27.

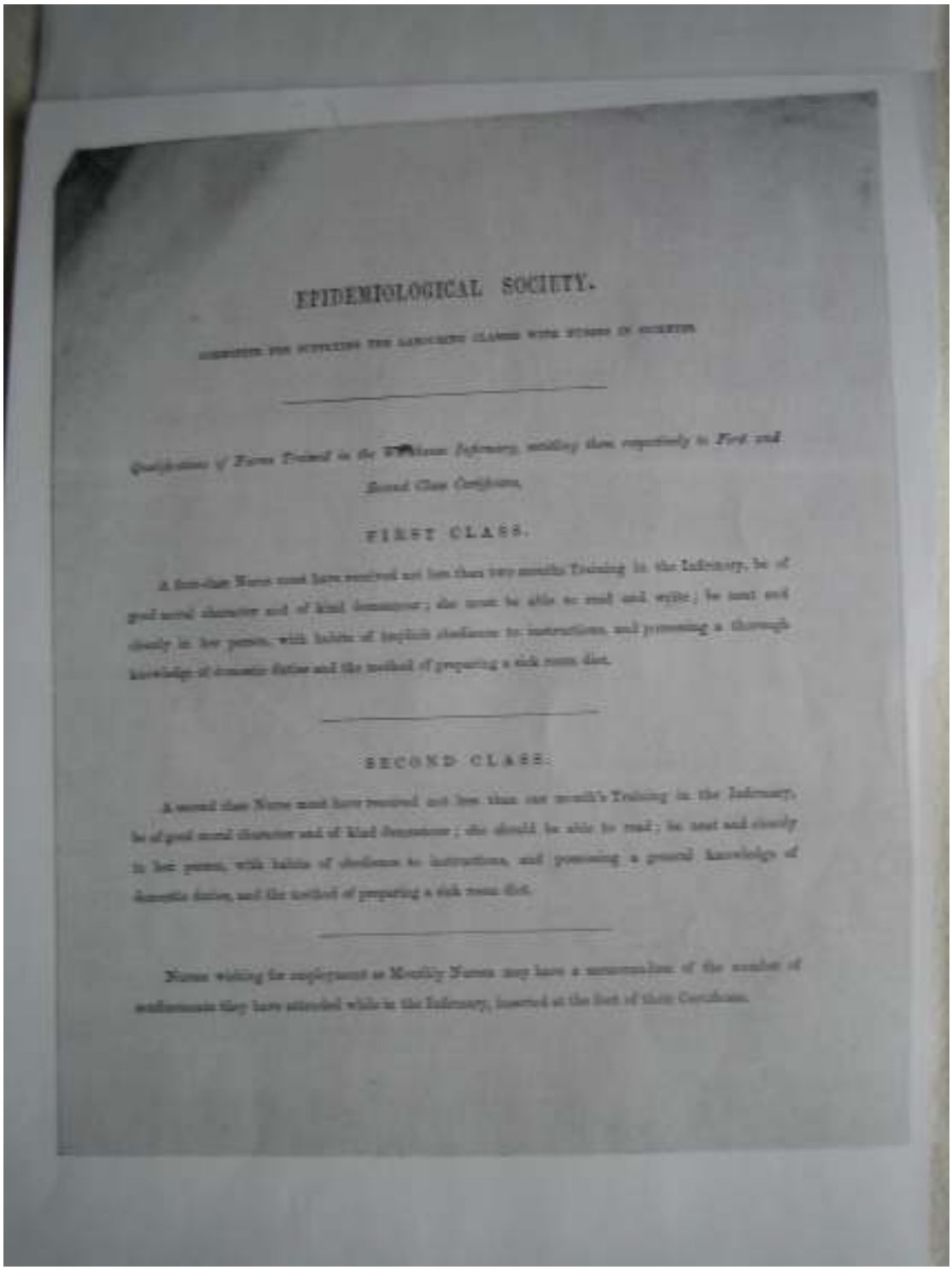
Elizabeth Wood's Temperature Chart, Birmingham Infirmary, 1885



Source: British Parliamentary Paper, 1886, (19-Sess. 2), p.29.

APPENDIX E

Qualification and Certificates for Nurse Training in Workhouses



EPIDEMIOLOGICAL SOCIETY.

Qualifications of Nurses Trained in the [illegible] Infirmary, entitling them respectively to First and Second Class Certificates.

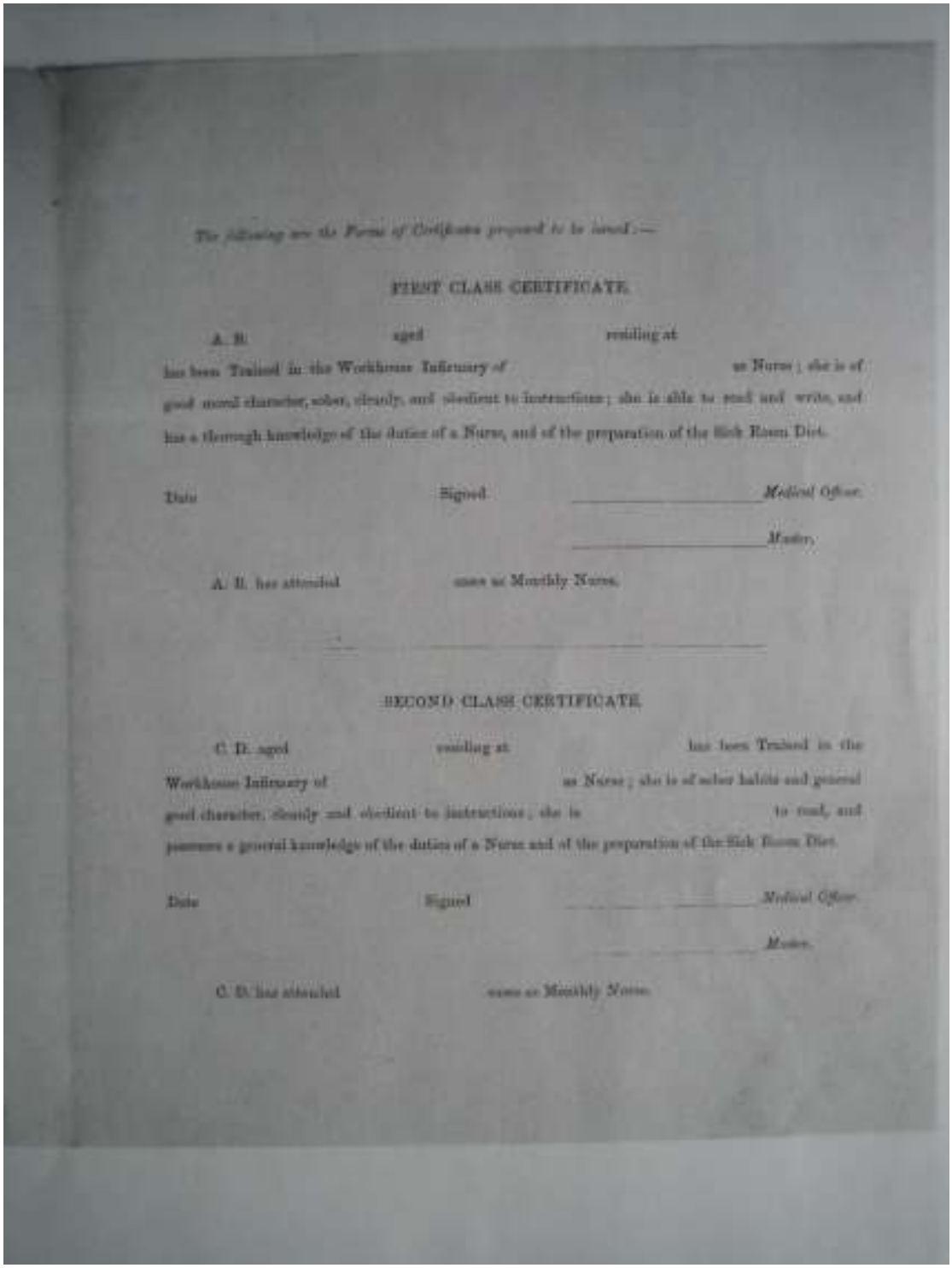
FIRST CLASS.

A first-class Nurse must have received not less than two months Training in the Infirmary, be of good moral character and of kind demeanour; she must be able to read and write; be neat and cleanly in her person, with habits of implicit obedience to instructions, and possessing a thorough knowledge of domestic duties and the method of preparing a sick room diet.

SECOND CLASS.

A second class Nurse must have received not less than one month's Training in the Infirmary, be of good moral character and of kind demeanour; she should be able to read; be neat and cleanly in her person, with habits of obedience to instructions, and possessing a general knowledge of domestic duties, and the method of preparing a sick room diet.

Nurses wishing for employment as Monthly Nurses may have a memorandum of the number of confinements they have attended while in the Infirmary, inserted at the foot of their Certificate.



The following are the Forms of Certificates proposed to be issued :—

FIRST CLASS CERTIFICATE.

A. B. aged residing at

has been Trained in the Workhouse Infirmary of as Nurse ; she is of good moral character, sober, cleanly, and obedient to instructions ; she is able to read and write, and has a thorough knowledge of the duties of a Nurse, and of the preparation of the Sick Room Diet.

Date Signed _____ *Medical Officer.*

_____ *Master.*

A. B. has attended cases as Monthly Nurse.

SECOND CLASS CERTIFICATE.

C. D. aged residing at has been Trained in the Workhouse Infirmary of as Nurse ; she is of sober habits and general good character, cleanly and obedient to instructions ; she is to read, and possesses a general knowledge of the duties of a Nurse and of the preparation of the Sick Room Diet.

Date Signed _____ *Medical Officer.*

_____ *Master.*

C. D. has attended cases as Monthly Nurse.

Source: Interleaved in Wolverhampton Archives and Local Studies, Wolverhampton Board of Guardians, PU/WOL/A/9, 1854-57.

APPENDIX F

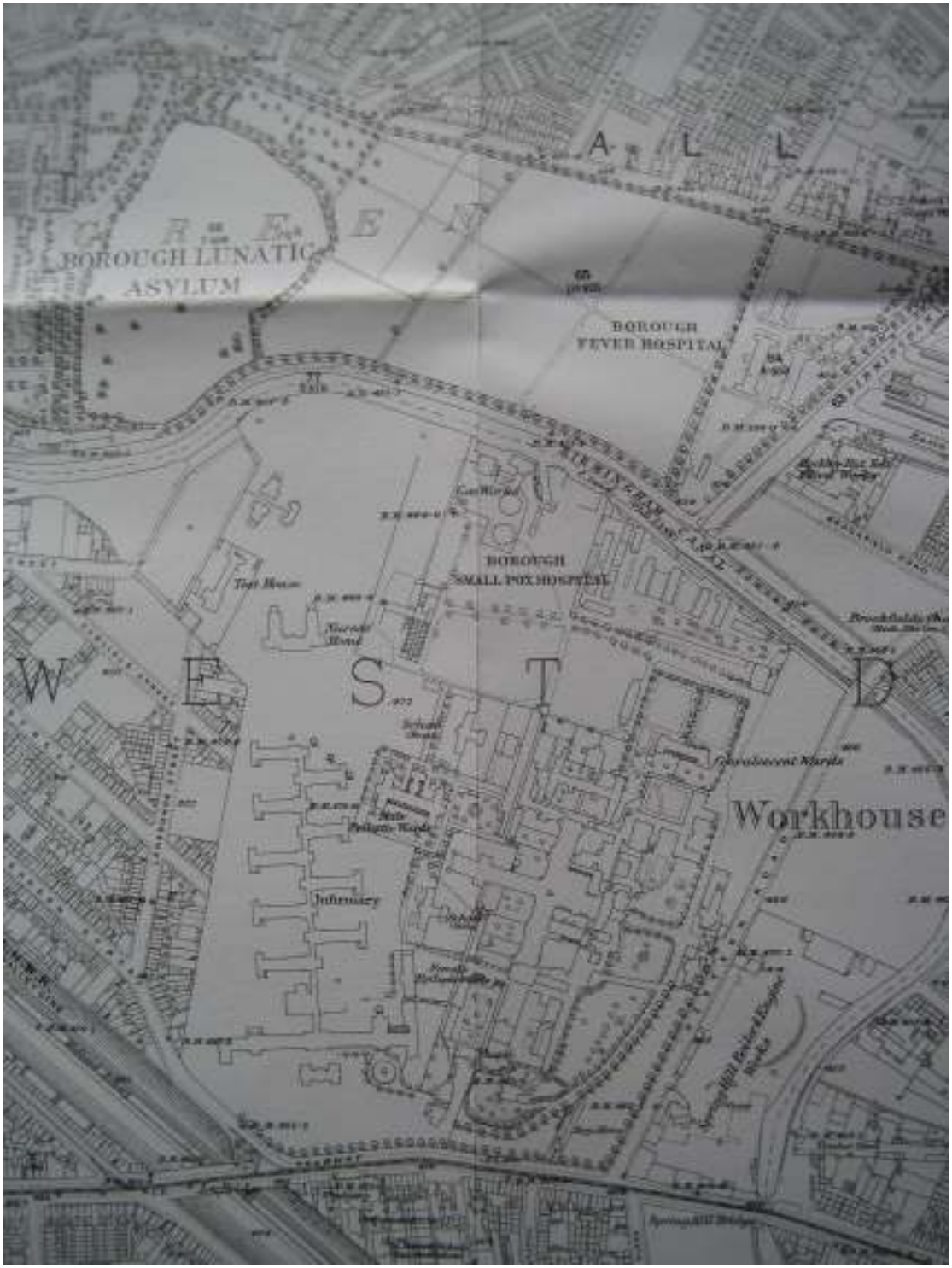
Situation of First Workhouse in Lichfield Street, Birmingham, 1810[1]

Source: The National Archives, MH12/13286.

[1] The Asylum for the Infant Poor and the General Hospital can be seen in Summer Lane.

APPENDIX G

Situation of Second Birmingham Workhouse and Infirmary, 1888[2]

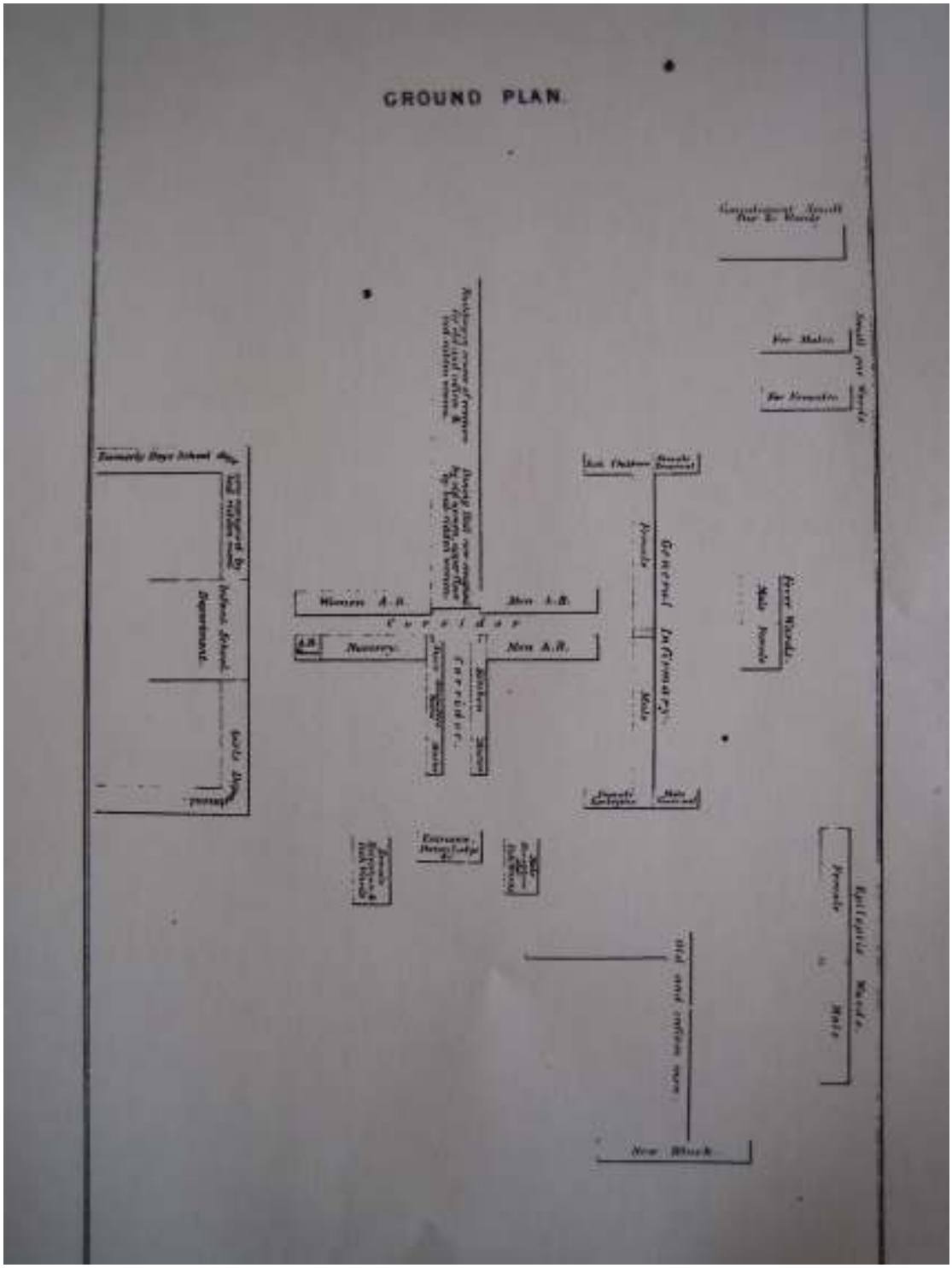


Source: Old Ordinance Survey Maps, Birmingham (Winson Green & Hockley), 1888, Alan Godfrey Maps, reprint 2012.

[2] The Borough Smallpox Hospital can be seen within the workhouse grounds and the Borough Fever Hospital on the opposite side of the canal, along with the Borough Lunatic Asylum.

APPENDIX H

Ground Plan of Second Birmingham Workhouse, 1867



Source: British Parliamentary Papers, 1846-47 (4), facing page 46.

APPENDIX I

Plan of First Wolverhampton Union Workhouse, 1871

Source: Wolverhampton Archives and Local Studies, DX-673/76, Sheet No. 76

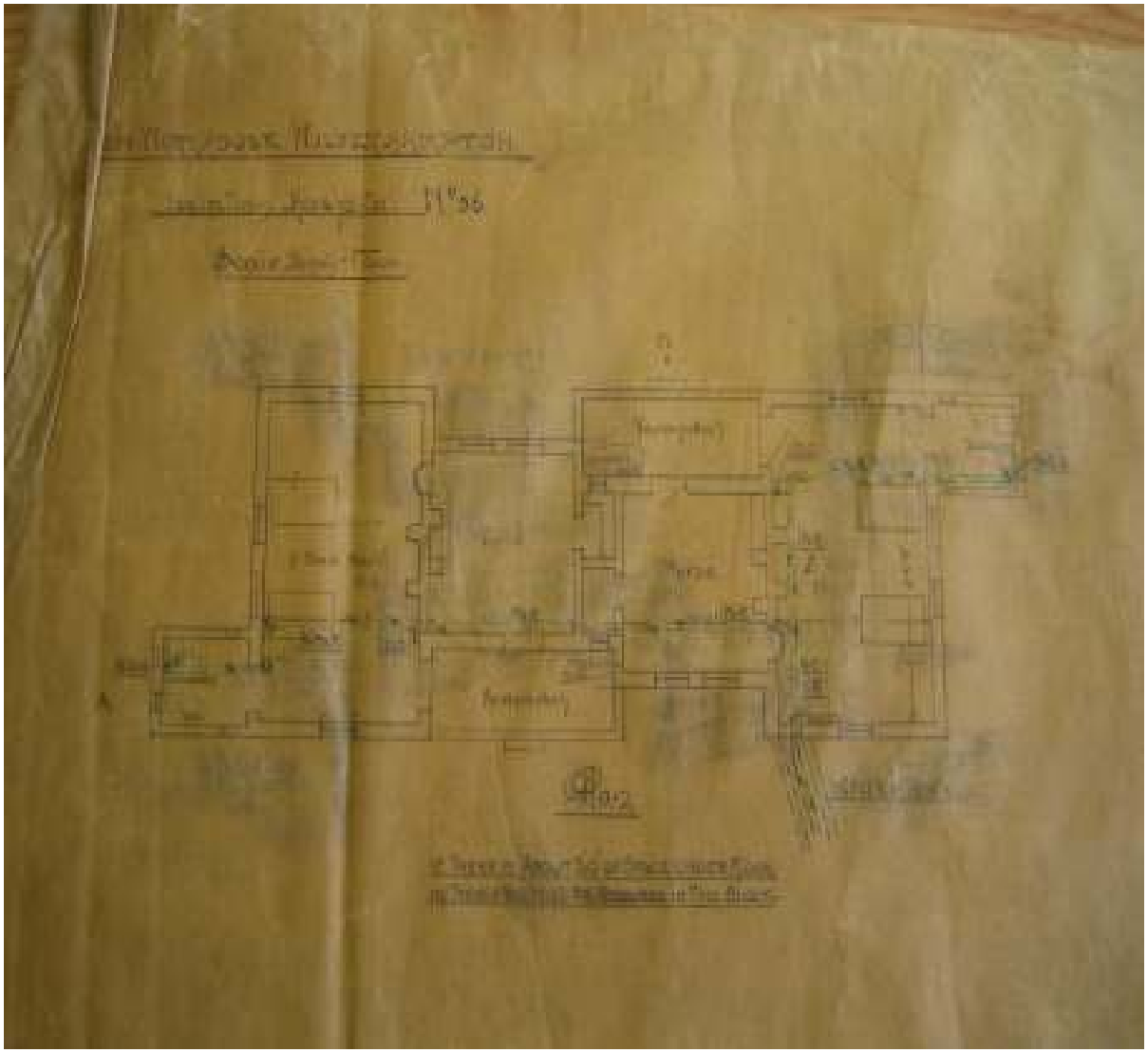
APPENDIX J

Plan of Second Wolverhampton Union Workhouse, 1902

Source: Wolverhampton Archives and Local Studies, DX/120/10/10, Block Plans of Workhouse (New Cross), 1902.

APPENDIX K

Plan of Isolation Hospital in Second Wolverhampton Workhouse, 1900



Source: Wolverhampton Archives and Local Studies, DX/120/10/4, Block Plans of Workhouse (New Cross), 1900**.**

APPENDIX L

Pauperism Rates and Institutionalisation Rates for Birmingham Parish, Wolverhampton Union and England and Wales, 1840-1911[1]

BIRMINGHAM					WOLVERHAMPTON				ENGLAND AND WALES	
Year	Total Paupers	Pauperism Rate	Indoor Paupers	Institutionalisation Rate	Total Paupers	Pauperism Rate	Indoor Paupers	Institutionalisation Rate	Pauperism Rate	Institutionalisation Rate
1840	7476	6.7%	716	10%	1102	2.3%	409	37%	7.7%	16%
1861	8889	4.2%	1404	16%	3563	3.2%	663	19%	4.3%	14%
1871	9768	4.2%	1701	17%	5332	4.5%	696	13%	4.3%	15%
1881	7586	3.1%	2320	31%	7815	6.1%	912	12%	3.0%	22%
1891	4495	1.8%	2672	59%	5312	3.9%	915	17%	2.5%	24%
1901	3599	1.5%	2290	64%	4581	3.0%	1142	25%	2.4%	21%
1911	5319	2.4%	3091	58%	3962	2.4%	1203	30%	2.1%	35%

Source: K. Williams, *From Pauperism to Poverty*, London, 1981, p.158; British Parliamentary Papers, 1840 (629), p.6, 1840 (543), p.2, 1861 (324B), pp.3, 42-43, 1871 (140 B.I.), pp.5, 6, 32-33, 1881 (60 B.I.), pp.iii, 30-31, 1890-91 (130 B.I.), pp.ii, 30-31, 1901 (73-I), p.ii, iii, 34-35, 1911 (263-I), pp.ii-iv, 14.

[1] Data for 1840 for Birmingham is based on the average weekly number of paupers for the year ending Lady Day, and for Wolverhampton the number for the quarter ending Lady Day. Pauper numbers for all other years are one-day counts on 1 July.

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GP/B/2/1/81-89	Minutes of Birmingham Union Board, 1912-1921
GP/B/2/3/2/1-6	Minutes of Workhouse Management Committee, 1887-1912
GP/B/2/3/1/1	Minutes of House Committee, 1842-1845
GP/B/2/3/3/1	Minutes of House Sub Committee, 1867-1910
GP/B/2/3/11/1	Minutes of Workhouse Inquiry, 1877-1878
GP/B/2/3/14/1-2	Minutes of House Committee, 1912-1917
GP/B/2/3/15/1-3	Minutes of Western Road House Sub Committee, 1912-1915
GP/B/2/4/1/1-5	Minutes of Infirmary Sub Committee, 1882-1888
GP/B/2/4/4/1-4	Minutes of Workhouse Infirmary Management Committee, 1888-1906
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MH12/1338	1881
MH12/13349	1885
MH12/13553	1886
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MH12/11691	1880
MH12/11711	1892
MH12/11715	1897-98
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